EXHIBIT A

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618,
  Lexington, KY 40512-4618
  If you need help filing a grievance, call the number on your ID card or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación **(TTY: 711)**... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 **(TTY: 711)**... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị **(TTY: 711)**... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 **(TTY: 711)**... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre **(ATS: 711)**...UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet **(TTY: 711)**... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください **(TTY: 711)**...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید **(TTY: 711)**...

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee néé ho'dólzin bikáá'ígíí bee hólne' **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك **(TTY: 711)**.

Humana.

Administrative Office:
1100 Employers Boulevard
Green Bay, Wisconsin 54344

Certificate of Coverage
Humana Employers Health Plan of Georgia, Inc.

Group Plan Sponsor: COOLING & WINTER, LLC

Group Plan Number: 852466

Effective Date: 03/01/2019

Product Name: GAEK0063 Copay F

Product Type: Health Maintenance Organization (HMO)

In accordance with the terms of the *master group contract* issued to the *group plan sponsor*, Humana Employers Health Plan of Georgia, Inc. certifies that a *covered person* has coverage for the benefits described in this *certificate.* This *certificate* becomes the Certificate of Coverage and replaces any and all certificates and certificate riders previously issued.

Bruce Broussard
President

This booklet, referred to as a Benefit Plan Document, is provided to describe *your* Humana coverage.

H200200GA 01/18

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FILING AN APPEAL

Should *you* have any questions regarding the denial, in whole or in part, of a proposed treatment plan or submitted claim, *you* may contact *us* directly at 1-800-901-1303. *We* will try to resolve *your* concerns at that time.

You are also entitled to have any Appeals heard by *us*. An Appeal is a written complaint submitted by *you* or *your* representative or a Provider acting on *your* behalf. *We* will review all pertinent information available to *us* relative to *your* Appeal. *You* will be promptly notified in writing of the outcome of the review.

To file a written Appeal, please submit all pertinent information to *us* at:

HUMANA GRIEVANCE & APPEALS OFFICE
P. O. BOX 14546
LEXINGTON, KY 40512

H201050GA 01/16

UNDERSTANDING YOUR COVERAGE

As *you* read the *certificate*, *you* will see some words are printed in italics. Italicized words may have different meanings in the *certificate* than in general. Please check the "Glossary" sections for the meaning of the italicized words as they apply to *your* plan.

The *certificate* gives *you* information about *your* plan. It tells *you* what is covered and what is not covered. It also tells *you* what *you* must do and how much *you* must pay for services. *Your* plan covers many services, but it is important to remember it has limits. Be sure to read *your certificate* carefully before using *your* benefits.
H202000 11/12

Essential health benefits

This *certificate* does not apply annual dollar limits or lifetime dollar limits to *covered expenses* that are *essential health benefits.*
H202050 01/18

Covered and non-covered expenses

We will provide coverage for services, equipment and supplies that are *covered expenses*. All requirements of the *master group contract* apply to *covered expenses*.

The date used on the bill *we* receive for *covered expenses* or the date confirmed in *your* medical records is the date that will be used when *your* claim is processed to determine the benefit period.

You must pay the health care provider any amount due that *we* do not pay. Not all services and supplies are a *covered expense*, even when they are ordered by a *health care practitioner*.

Refer to the "Schedule of Benefits," the "Covered Expenses," "Covered Expenses – Clinical Trials" and the "Limitations and Exclusions" sections and any amendment attached to the *certificate* to see when services or supplies are *covered expenses* or are non-covered expenses.
H202100GA 01/19

How your master group contract works

You may have to pay a *deductible* before *we* pay for certain *covered expenses*. If a *deductible* applies, and it is met, *we* will pay *covered expenses* at the *coinsurance* amount. Refer to the "Schedule of Benefits" to see when the *deductible* applies and the *coinsurance* amount *we* pay. *You* will be responsible for the *coinsurance* amount *we* do not pay.

If an *out-of-pocket limit* applies, and it is met, *we* will pay *covered expenses* at 100% the rest of the *year*, subject to the *maximum allowable fee*.

UNDERSTANDING YOUR COVERAGE (continued)

Our payment for *covered expenses* is calculated by applying any *deductible* and *coinsurance* to what *we* allow. For a *covered expense, we* will allow the total amount billed by the *qualified provider,* less any amounts such as:

- Those negotiated by contract, directly or indirectly, between *us* and the *qualified provider*;
- Those in excess of the *maximum allowable fee*; or
- Adjustments related to *our* claims processing procedures.

The service and diagnostic information submitted on the *qualified provider's* bill will be used to determine which provision of the "Schedule of Benefits" applies.
H202150 01/18

Your choice of providers affects your benefits

We may appoint certain *network providers* for certain kinds of services. If *you* do not see the appointed *network provider* for these services, *we* may pay less.

Some *non-network providers* work with *network hospitals*. *We* will apply the *network provider copayment, deductible* and *coinsurance* to *covered expenses* received by non-network pathologists, anesthesiologists, radiologists, and emergency room physicians working with *network hospitals*. However, *you* may still have to pay these *non-network providers* any amount over the *maximum allowable fee.* If possible, *you* may want to check if all health care providers working with *network hospitals* are *network providers*.

Refer to the "Schedule of Benefits" sections to see what *your* benefits are.
H202400 01/16

How to find a network provider

You may find a list of *network providers* at www.humana.com. This list is subject to change and may be updated at least every 30 days. Please check this list before receiving services from a *qualified provider*. *You* may also call *our* customer service department at the number listed on *your* ID card to determine if a *qualified provider* is a *network provider,* or *we* can send the list to *you.* A *network provider* can only be confirmed by *us.*
H202420GA 01/16

How to use your health maintenance organization (HMO) plan

You may receive services from a *network provider* with *your* HMO plan without a referral from *your primary care physician*. Refer to the "Schedule of Benefits" for any *preauthorization* requirements.
H202440 11/12

UNDERSTANDING YOUR COVERAGE (continued)

Use of network providers

In most cases, there are *network providers* for *your* health care. *Network providers* have agreed to provide *covered expenses* at lower costs. *You* must pay any *copayment, deductible* or *coinsurance you* owe to the *network provider*. The *network provider* will accept *your copayment, deductible* or *coinsurance* and the amount *we* pay as the full payment. *You* will not be billed for charges over the *maximum allowable fee*.

Be sure to determine if *your* provider is a *network provider* before *you* receive services from them. *We* offer many health care plans, and a *qualified provider* who is a *network provider* for one plan may not be a *network provider* for this plan.

We may designate certain *network providers* for certain kinds of services.
H202610 01/16

Use of non-network providers

If a *network provider* cannot provide the *covered expenses you* need or they cannot treat *your* condition, *you* must have a referral from *your primary care physician* that is approved by *us* to receive services from a *non-network provider*. Only the services approved by *us* will be a *covered expense. Non-network providers* have not signed an agreement with *us* for lower costs for services and they may bill *you* for any amount over the *maximum allowable fee*. *You* will have to pay this amount and any *copayment, deductible* and *coinsurance*. Any amount over the *maximum allowable fee* will not apply to *your deductible* or any *out-of-pocket limit.*
H202620 01/16

Seeking emergency care

If *you* need *emergency care*:

- Go to the nearest *network hospital* emergency room; or
- Find the nearest *hospital* emergency room if *your* condition does not allow *you* to go to a *network hospital.*

UNDERSTANDING YOUR COVERAGE (continued)

You, or someone on *your* behalf, must call *us* within 48 hours after *your admission* to a *non-network hospital* for *emergency care.* If *your* condition does not allow *you* to call *us* within 48 hours after *your admission,* contact *us* as soon as *your* condition allows. *We* may transfer *you* to a *network hospital* in the *service area* when *your* condition is stable. *You* must receive services from a *network provider* for any follow-up care.
H203000 01/16

Seeking urgent care

If *you* need *urgent care, you* must go to the nearest network *urgent care center* for the *network provider* benefit *copayment, deductible* or *coinsurance* to apply. *You* must receive services from a *network provider* for any follow-up care for the *network provider copayment, deductible* or *coinsurance* to apply.
H203100 01/16

Our relationship with qualified providers

Qualified providers are not *our* agents, employees or partners. All providers are independent contractors. *Qualified providers* make their own clinical judgments or give their own treatment advice without decisions made by *us*.

The *master group contract* will not change what is decided between *you* and *qualified providers* regarding *your* medical condition or treatment options. *Qualified providers* act on *your* behalf when they order services. *You* and *your qualified providers* make all decisions about *your* health care, no matter what *we* cover. *We* are not responsible for anything said or written by a *qualified provider* about *covered expenses* and/or what is not covered under this *certificate.* Please call *our* customer service department at the telephone number listed on *your* ID card if *you* have any questions.
H203400 01/18

Our financial arrangements with network providers

We have agreements with *network providers* that may have different payment arrangements:

- Many *network providers* are paid on a discounted fee-for-services basis. This means they have agreed to be paid a set amount for each *covered expense*;
- Some *network providers* may have capitation agreements. This means the *network provider* is paid a set dollar amount each month to care for each *covered person* no matter how many services a *covered person* may receive from the *network provider*, such as a *primary care physician* or a *specialty care physician*;
- *Hospitals* may be paid on a Diagnosis Related Group (DRG) basis or a flat fee per day basis for *inpatient* services. *Outpatient* services are usually paid on a flat fee per service or a procedure or a discount from their normal charges.

H203500 01/19

UNDERSTANDING YOUR COVERAGE (continued)

The certificate

The *certificate* is part of the *master group contract* and tells *you* what is covered and not covered and the requirements of the *master group contract.* Nothing in the *certificate* takes the place of or changes the terms of the *master group contract.* The final interpretation of any provision in the *certificate* is governed by the *master group contract.* If the *certificate* is different than the *master group contract,* the provisions of the *master group contract* will apply. The benefits in the *certificate* apply if *you* are a *covered person.*
H203700 11/12

SCHEDULE OF BENEFITS

Reading this "Schedule of Benefits" section will help *you* understand:

- *Preauthorization* requirements;
- The level of benefits *we* generally pay for *covered expenses* and what *you* may be responsible for, including:
  - *Copayments* that may apply for each *covered expense. You* may be responsible for more than one *copayment* during the same visit with the same provider;
  - The *covered expenses* that require *you* to meet a *deductible,* if any, before benefits are paid by *us*; and
  - The *coinsurance you* are required to pay for *covered expenses*; and
- *Your* maximum *out-of-pocket limit*.

This "Schedule of Benefits" outlines the coverage and limitations provided under the *master group contract.* A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses" and "Limitations and Exclusions" sections of this *certificate.*

The benefits outlined under the "Schedule of Benefits – Behavioral Health," "Schedule of Benefits – Transplant Services," and "Schedule of Benefits – Pharmacy Services" sections are not payable under any other Schedule of Benefits of the *master group contract.* However, all other terms and provisions of the *master group contract* apply, including the *preauthorization* requirements, annual *deductible(s)* and any *out-of-pocket limit(s),* unless otherwise stated.
HSCH1-1100 01/19

Network provider verification

This *certificate* contains multiple benefit levels. Refer to each Schedule of Benefits to see what benefit levels apply to *covered expenses*.

Refer to the Online Provider Finder on *our* Website at www.humana.com for a list of *network providers*. *You* may also contact *our* customer service department at the telephone number shown on *your* ID card. This list is subject to change, but is updated no less than every 30 days.
HSCH1-1200GA 01/17

Preauthorization requirements

Preauthorization by *us* is required for certain services and supplies. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* ID card to obtain a list of services and supplies that require *preauthorization.* The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization,* is not a guarantee of future coverage of the same services or supplies.

SCHEDULE OF BENEFITS (continued)

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements. *You* or *your health care practitioner* must contact *us* by telephone, *electronic mail*, or in writing to request the appropriate authorization. *Your* ID card will show the *health care practitioner* the telephone number to call to request authorization. Benefits are not paid at all for services or supplies that are not *covered expenses*.
HSCH1-1500GA 01/17

Annual deductible

An annual *deductible* is a specified dollar amount that *you* must pay for *covered expenses*, except for any *deductible* met for *prescriptions* or *specialty drugs* from a *pharmacy* or *specialty pharmacy*, per *year* before any applicable *coinsurance* applies and most benefits are paid under the *master group contract*. There are individual and family *network provider deductibles*. The *deductible* amount(s) for each *covered person* and each covered family are as follows, and must be satisfied each *year*, either individually or combined as a covered family. *Covered expenses* that apply to the individual *deductible* also apply to the family *deductible*. Once a *covered person* meets the individual *deductible*, the *coinsurance* will then apply to applicable *covered expenses* for that *covered person*. Once the family *deductible* is met, any remaining individual *deductible* for a *covered person* in the family will be waived for that *year*. The *coinsurance* will then apply to applicable *covered expenses* for all *covered persons* in the family. *Copayments* do not apply toward the annual *deductible*.

Deductible	**Deductible amount**
Individual *network provider deductible*	$1,500
Family *network provider deductible*	$3,000

HSCH1-1600 01/19

Annual deductible carryover

If a *covered person* incurs *covered expenses* during the last three months of the current *year* that are applied toward the satisfaction of the *deductible* for that *year*, those same *covered expenses* will also be applied toward the satisfaction of the *deductible* of the next *year*.
HSCH1-1700GA 01/19

SCHEDULE OF BENEFITS (continued)

Maximum out-of-pocket limit

The *out-of-pocket limit* is the maximum amount of any *copayments*, *deductibles* and/or *coinsurance* for *covered expenses* that must be paid by *you*, either individually or combined as a covered family, per *year* before a benefit percentage for *covered expenses* will be increased. There are individual and family *network provider out-of-pocket limits*.

After the individual *network provider out-of-pocket limit* has been satisfied in a *year*, the *network provider* benefit percentage for *covered expenses* for that *covered person* will be payable by *us* at the rate of 100% for the rest of the *year*, subject to any maximum benefit and all other terms, provisions, limitations, and exclusions of the *master group contract*. *Covered expenses* that apply to the individual *out-of-pocket limit* also apply to the family *out-of-pocket limit*. After the family *network provider out-of-pocket limit* has been satisfied in a *year*, the *network provider* benefit percentage for *covered expenses* will be payable by *us* at the rate of 100% for the rest of the *year* for all *covered persons* in the family, subject to any maximum benefit and all other terms, provisions, limitations, and exclusions of the *master group contract*.

If any *copayment*, *deductible* or *coinsurance* amount applied to *your* claim is waived by *your* health care provider, *you* are required to inform *us*. Any amount, thus waived and not paid by *you*, would not apply to any *out-of-pocket limit*.

Maximum out-of-pocket limit	**Maximum out-of-pocket limit amount**
Individual *network provider out-of-pocket limit*	$4,000
Family *network provider out-of-pocket limit*	$8,000

HSCH1-1900 01/19

SCHEDULE OF BENEFITS (continued)

Preventive services

Includes *preventive services* and prostate specific antigen (PSA) test. Does not include drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list.* Refer to the "Schedule of Benefits - Pharmacy Services" section in this *certificate.*

Network provider	Covered in full

Child health supervision birth through age 5

Routine exam

Primary care physician	Covered in full
Specialty care physician	Covered in full

Routine laboratory

Primary care physician	Covered in full
Specialty care physician	Covered in full

Routine immunizations

Primary care physician	Covered in full
Specialty care physician	Covered in full

SCHEDULE OF BENEFITS (continued)

Health care practitioner office services

Health care practitioner office visit

Primary care physician	$25 *copayment* per visit
Specialty care physician	$50 *copayment* per visit

Diagnostic laboratory and radiology services when performed in the office and billed by the health care practitioner

Does not include *advanced imaging.* Refer to "Advanced imaging when performed in a health care practitioner's office" in this "Schedule of Benefits" section.

Primary care physician	Covered in full
Specialty care physician	Covered in full

Advanced imaging when performed in a health care practitioner's office

Primary care physician	Covered in full after *network provider deductible*
Specialty care physician	Covered in full after *network provider deductible*

SCHEDULE OF BENEFITS (continued)

Allergy serum when received in the health care practitioner's office

Primary care physician	Covered in full
Specialty care physician	Covered in full

Allergy injections when received in a health care practitioner's office

Primary care physician	$5 *copayment* per visit
Specialty care physician	$5 *copayment* per visit

Injections other than allergy when received in a health care practitioner's office

Primary care physician	$5 *copayment* per visit
Specialty care physician	$5 *copayment* per visit

SCHEDULE OF BENEFITS (continued)

Surgery performed in the office and billed by the health care practitioner

Primary care physician	Covered in full after *network provider deductible*
Specialty care physician	Covered in full after *network provider deductible*

Health care practitioner services at a retail clinic

Health care practitioner office visit in a retail clinic

Primary care physician	$40 *copayment* per visit

Diagnostic laboratory when performed by a health care practitioner in a retail clinic

Primary care physician	Covered in full

Injections other than allergy when received by a health care practitioner in a retail clinic

Primary care physician	$5 *copayment* per visit

SCHEDULE OF BENEFITS (continued)

Hospital services

Hospital inpatient services

Network hospital	Covered in full after *network provider deductible*

Health care practitioner inpatient services when provided in a hospital

Primary care physician	Covered in full after *network provider deductible*
Specialty care physician	Covered in full after *network provider deductible*

Hospital outpatient surgical services

Must be performed in a *hospital's outpatient* department.

Network hospital	Covered in full after *network provider deductible*

SCHEDULE OF BENEFITS (continued)

Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery.*

Primary care physician	Covered in full after *network provider deductible*
Specialty care physician	Covered in full after *network provider deductible*

Hospital outpatient non-surgical services

Must be performed in a *hospital's outpatient* department. Does not include diagnostic radiology, diagnostic laboratory and *advanced imaging.* Refer to "Hospital outpatient diagnostic radiology and laboratory" and "Hospital outpatient advanced imaging" in this "Schedule of Benefits" section.

Network hospital	Covered in full after *network provider deductible*

Hospital outpatient diagnostic radiology and laboratory

Network hospital	Covered in full after *network provider deductible*

SCHEDULE OF BENEFITS (continued)

Hospital outpatient advanced imaging

Must be performed in a *hospital's outpatient* department.

Network hospital	Covered in full after *network provider deductible*

Pregnancy and newborn benefit

Same as any other *sickness* based upon location of services and the type of provider.

Emergency services

Must be for *emergency care* as defined in the "Glossary" section.

Hospital emergency room services

Does not include *advanced imaging.* Refer to "Hospital emergency room advanced imaging" in this "Schedule of Benefits" section.

Network hospital	$350 *copayment* per visit. *Copayment* waived if admitted.

Hospital emergency room advanced imaging

Network hospital	*coinsurance* after *network provider deductible*

SCHEDULE OF BENEFITS (continued)

Hospital emergency room health care practitioner services

Network health care practitioner	Covered in full

Ambulance services

Network provider	Covered in full after *network provider deductible*

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

Network provider	Covered in full after *network provider deductible*

Health care practitioner outpatient services when provided in an ambulatory surgical center

Includes *outpatient surgery.*

Primary care physician	Covered in full after *network provider deductible*
Specialty care physician	Covered in full after *network provider deductible*

SCHEDULE OF BENEFITS (continued)

Durable medical equipment

Network provider	Covered in full after *network provider deductible*

Diabetes equipment and supplies

Same as any other *sickness* based upon location of service and type of provider.

Hearing aid devices and services

Limited to a maximum of $3,000.00 per *hearing aid*, per hearing impaired ear during a 48-month period for *covered persons* under the age of 19.

Network provider	Covered in full after *network provider deductible*

Free-standing facility services

Free-standing facility non-surgical services

Does not include *advanced imaging.* Refer to "Free-standing facility advanced imaging" in this "Schedule of Benefits" section.

Network provider	Covered in full

Health care practitioner non-surgical services when provided in a free-standing facility

Primary care physician	Covered in full after *network provider deductible*
Specialty care physician	Covered in full after *network provider deductible*

SCHEDULE OF BENEFITS (continued)

Free-standing facility advanced imaging

Network provider	Covered in full after *network provider deductible*

Home health care services

Limited to a maximum of 100 visits per *year*.

Network provider	Covered in full after *network provider deductible*

Hospice services

Network provider	Covered in full after *network provider deductible*

Jaw joint benefit

Same as any other *sickness* based upon location of service and type of provider.

Physical medicine and rehabilitative services

Physical therapy, occupational therapy, speech therapy, audiology services, cognitive rehabilitation services, and spinal manipulations/adjustments are limited to a combined maximum of 30 visits per *year*.

Network provider	$50 *copayment* per visit

SCHEDULE OF BENEFITS (continued)

Respiratory or pulmonary rehabilitation services

Network provider	Covered in full after *network provider deductible*

Cardiac rehabilitation services

Network provider	Covered in full after *network provider deductible*

Other therapy

Includes radiation therapy and chemotherapy.

Network provider	Covered in full after *network provider deductible*

Skilled nursing facility services

Limited to a maximum of 60 days per *year*.

Network provider	Covered in full after *network provider deductible*

Health care practitioner services when provided in a skilled nursing facility

Network health care practitioner	Covered in full after *network provider deductible*

SCHEDULE OF BENEFITS (continued)

Specialty drugs in a medical place of service

Specialty drugs administered in a health care practitioner's office, free-standing facility and urgent care center

Network provider	$50 *copayment* per visit

Specialty drugs administered in home health care

Network provider designated by *us* as a preferred provider of *specialty drugs*	Covered in full
Network provider	$50 *copayment* per visit

Specialty drugs administered in a hospital, skilled nursing facility, ambulance or emergency room

Same as any other *sickness* based upon location of services and the type of provider.

Urgent care services

Network provider	$75 *copayment* per visit

Additional covered expenses

Same as any other *sickness* based upon location of services and the type of provider.
HSCH2GA 01/19

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH

Reading this "Schedule of Benefits – Behavioral Health" section will help *you* understand the level of benefits *we* generally pay for *mental health services* and *chemical dependency* services under the *master group contract.*

This "Schedule of Benefits – Behavioral Health" outlines the coverage and limitations provided under the *master group contract.* A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses," "Covered Expenses – Behavioral Health" and "Limitations and Exclusions" sections of this *certificate.* Refer to the "Schedule of Benefits" section for *behavioral health covered expenses* not listed in this section.

All services are subject to all the terms and provisions, limitations and exclusions of the *master group contract.*

Acute inpatient services

Network hospital	Covered in full after *network provider deductible*

Partial hospitalization services

Network provider	Covered in full after *network provider deductible*

Acute inpatient and partial hospitalization health care practitioner services

Network health care practitioner	Covered in full after *network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Emergency services

Must be for *emergency care* as defined in the "Glossary" section.

Hospital emergency room services

Does not include *advanced imaging.* Refer to "Hospital emergency room advanced imaging" in this "Schedule of Benefits – Behavioral Health" section.

Network hospital	$350 *copayment* per visit. *Copayment* waived if admitted.

Hospital emergency room advanced imaging

Network hospital	Covered in full

Hospital emergency room health care practitioner services

Network health care practitioner	Covered in full

Urgent care services

Network provider	Covered in full

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Outpatient services

Health care practitioner office visit

Does not include *behavioral health* therapy in a *health care practitioner's* office. Refer to "Therapy" in this "Schedule of Benefits – Behavioral Health" section.

Primary care physician	$25 *copayment* per visit
Specialty care physician	$25 *copayment* per visit

Telehealth and telemedicine services

Does not include *inpatient telehealth* and *telemedicine* services. Refer to the "Additional covered expenses" provision in the "Covered Expenses" section.

Network provider	$25 *copayment* per visit

Health care practitioner office visit in a retail clinic

Network health care practitioner	$25 *copayment* per visit

Injections when performed in a health care practitioner's office or retail clinic

Does not include *preventive services* and allergy injections. Refer to "Preventive services" and "Allergy injections when received in a health care practitioner's office" in the "Schedule of Benefits" section.

Network health care practitioner	Covered in full

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Therapy

Includes *outpatient behavioral health* therapy and *behavioral health* therapy in a *health care practitioner's* office. Also includes *behavioral health* physical therapy, occupational therapy, speech therapy, audiology services, cognitive therapy, and nutritional counseling.

Network provider	$25 *copayment* per visit

Outpatient hospital services

Does not include *outpatient* therapy. Refer to "Therapy" in this "Schedule of Benefits – Behavioral Health" section.

Does not include *advanced imaging.* Refer to "Advanced imaging performed in a health care practitioner's office, hospital outpatient department or free-standing facility" in this "Schedule of Benefits – Behavioral Health" section.

Network hospital	Covered in full after *network provider deductible*

Advanced imaging performed in a health care practitioner's office, hospital outpatient department or free-standing facility

Network provider	Covered in full after *network provider deductible*

Skilled nursing facility services

Network provider	Covered in full after *network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Home health care services

Does not include applied behavioral analysis therapy. Refer to "Applied behavioral analysis therapy during a home health care visit" in this "Schedule of Benefits – Behavioral Health" section.

Network provider	Covered in full after *network provider deductible*

Applied behavioral analysis therapy during a home health care visit

Network provider	$25 *copayment* per visit

Specialty drugs in a medical place of service

Specialty drugs administered in a health care practitioner's office, free-standing facility and urgent care center

Network provider	Covered in full

Specialty drugs administered in home health care

Network provider designated by *us* as a preferred provider of *specialty drugs*	Covered in full
Network provider	Covered in full

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Residential treatment facility services

Same as any other *behavioral health* services for *inpatient* or *outpatient covered expenses*.

Autism spectrum disorders

Same as any other *behavioral health sickness* based upon location of services and the type of provider.
HSCHGA BH 01/19

SCHEDULE OF BENEFITS – TRANSPLANT SERVICES

Reading this "Schedule of Benefits – Transplant Services" section will help *you* understand the level of benefits *we* generally pay for the transplant services covered under the *master group contract.*

This "Schedule of Benefits – Transplant Services" outlines the coverage and limitations provided under the *master group contract.* A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Transplant Services" and "Limitations and Exclusions" sections of this *certificate.*

All services are subject to all of the terms, provisions, limitations and exclusions of the *master group contract.*

Hospital services

Hospital benefits as shown under "Hospital services" in the "Schedule of Benefits" section of this *certificate* will be payable as follows:

Network hospital designated by *us* as an approved transplant facility	Same as any other *sickness* based on location of services and type of provider.

Health care practitioner services

Health care practitioner benefits as shown under "Health care practitioner office services" in the "Schedule of Benefits" section of this *certificate* will be payable as follows:

Network health care practitioner designated by *us* as an approved transplant *health care practitioner*	Same as any other *sickness* based on location of services and type of provider.

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES (continued)

Direct, non-medical costs

Limited to a combined maximum coverage of $10,000 per covered transplant.

- Transportation

Network hospital designated by *us* as an approved transplant facility	Covered in full

- Temporary lodging

Network hospital designated by *us* as an approved transplant facility	Covered in full

HSCHGA-OT 01/19

SCHEDULE OF BENEFITS - PHARMACY SERVICES

Reading this "Schedule of Benefits – Pharmacy Services" section will help *you* understand:

- The level of benefits *we* generally pay for the *prescription* drugs, medicines or medications, including *specialty drugs*, covered under the *master group contract*;
- The *copayment* and/or *coinsurance* amount *you* are required to pay;
- The required *prescription drug deductible* amount to be met, if any, before benefits are paid; and
- *Prior authorization* requirements.

This "Schedule of Benefits – Pharmacy Services" outlines the coverage and limitations provided under the *master group contract.* A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Pharmacy Services," "Limitations and Exclusions" and "Limitations and Exclusions – Pharmacy Services" sections of this *certificate.*

Covered expenses for *prescription* drugs and *specialty drugs* obtained from a *network pharmacy* under provisions of this benefit apply toward *your out-of-pocket limit.*

For the purposes of coordination of benefits, *prescription* drug coverage under this benefit will be considered a separate plan and will therefore only be coordinated with other *prescription* drug coverage.

All terms used in this "Schedule of Benefits – Pharmacy Services" have the meaning given to them in the "Glossary" section, unless otherwise specifically defined in the "Glossary – Pharmacy Services" section of this *certificate*. All services are subject to all of the terms, provisions, limitations and exclusions of the *master group contract,* unless otherwise stated.

Prior authorization requirements

Prior authorization and/or *step therapy* is required for certain *prescription* drugs, medicines or medications, including *specialty drugs*. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain *our drug list* that identifies the drugs, medicines or medications, including *specialty drugs* that require *prior authorization* and/or *step therapy.* The *drug list* is subject to change. Coverage provided in the past is not a guarantee of future coverage.

Your health care practitioner must contact *our* Clinical Pharmacy Review to request and receive *our* approval for *prescription* drugs, medicines or medications, including *specialty drugs* that require *prior authorization* and/or *step therapy.* Benefits are payable only if approved by *us*.

Preventive medication coverage

Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* are covered in full when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

Prescription drug cost sharing

You are responsible for any and all *cost share*, when applicable, as specified below. If the dispensing *pharmacy's* charge is less than *your copayment* or *coinsurance* for *prescription* drugs, *you* will be responsible for the dispensing *pharmacy* charge amount. The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. *Your copayment* or *coinsurance* is made on a per *prescription* fill or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or *prescription* drug rebates.

Prescription synchronization

We will cover a *prescription* dispensed by a *pharmacy* for less than a 30-day supply, when requested by *you*, to synchronize *your prescriptions* that treat a permanent or long-term *sickness* or *bodily injury*. Synchronizing *your prescriptions* is to align the dispensing of multiple *prescriptions* by a *pharmacy*. *Your* prescribing *health care practitioner* or the *pharmacist* will determine if synchronizing the fill or refill of *your prescription* is in *your* best interest. The *cost share* for a partial supply of a *prescription* will be prorated when dispensed to synchronize *your prescriptions*.

Retail pharmacy — Coverage for up to a 30-day supply

Specialty drugs are not included. Refer to the "Specialty pharmacy / Retail pharmacy" provision below for *specialty drug* benefits.

Network pharmacy level 1 drugs	$10 *copayment* per *prescription* fill or refill
Network pharmacy level 2 drugs	$35 *copayment* per *prescription* fill or refill
Network pharmacy level 3 drugs	$55 *copayment* per *prescription* fill or refill
Network pharmacy level 4 drugs	25% *coinsurance* per *prescription* fill or refill

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

90-day Retail pharmacy

Some retail *pharmacies* participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill. *Your* cost is 3 times the applicable *copayment* outlined above, or the applicable *coinsurance* amount, if any, as specified above. *Specialty drugs* are limited to a 30-day supply from a *specialty pharmacy* or a retail *pharmacy*, unless otherwise determined by *us*.

Mail order pharmacy — 90-day supply

Specialty drugs are not included. Refer to the "Specialty pharmacy / Retail pharmacy" provision below for *specialty drug* benefits.

Network pharmacy level 1 drugs, level 2 drugs and *level 3 drugs*	2.5 times the applicable *copayment* per *prescription* fill or refill, as outlined above under "Retail pharmacy"
Network pharmacy level 4 drugs	25% *coinsurance* per *prescription* fill or refill

Specialty pharmacy / Retail pharmacy — Coverage for up to a 30-day supply

Network pharmacy designated by *us* as a preferred provider of *specialty drugs*	25% *coinsurance* per *specialty drug prescription* fill or refill
Network pharmacy provider of *specialty drugs*	35% *coinsurance* per *specialty drug prescription* fill or refill

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

Oral cancer treatment medications

Your cost share for covered orally administered cancer treatment medications will not exceed $200 per *prescription* fill or refill.

Dispense as written

If *you* request a *brand-name drug* when a *generic drug* is available, *your cost share* is greater. *You* are responsible for the applicable *brand-name drug copayment* or *coinsurance* and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name drug* and the amount *we* would have paid the dispensing *pharmacy* for the *generic drug.* If the prescribing *health care practitioner* determines that the *brand-name drug* is *medically necessary*, *you* are only responsible for the applicable *copayment* or *coinsurance* of the *brand-name drug*.
HSCH-PSGA 01/19

COVERED EXPENSES

This "Covered Expenses" section describes the services that will be considered *covered expenses* under the *master group contract.* Benefits will be paid for covered medical services for a *bodily injury* or *sickness,* or for specified *preventive services,* on a *maximum allowable fee* basis and as shown on the "Schedules of Benefits," subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate.* All terms and provisions of the *master group contract* apply, including *preauthorization* specified in this *certificate.*
H204000 01/18

Preventive services

Covered expenses include the *preventive services* appropriate for *you* as recommended by the U.S. Department of Health and Human Services (HHS) for *your* plan *year*. *Preventive services* include:

- Services with an A or B rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF).
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- Preventive care for women provided in the comprehensive guidelines supported by HRSA.

For the recommended *preventive services* that apply to *your* plan *year*, refer to the www.healthcare.gov website or call the customer service telephone number on *your* identification card.
H204200GA 01/17

Child health supervision benefit

Benefits are payable for the periodic review of physical and emotional health for a covered *dependent* child from birth through age five. *Covered expenses* for each visit shall include the following services in keeping with prevailing medical standards:

- A medical history;
- Physical examination;
- Developmental assessment and anticipatory guidance;
- Appropriate immunizations and laboratory tests;
- Hearing screenings; and
- Vision screenings.

Benefits are limited to the above services provided by or under the supervision of one *health care practitioner* during the course of one visit. Benefits do not include periodic dental examinations or other dental services. The *deductible,* if any, does not apply.
H204250GA 02/11

COVERED EXPENSES (continued)

Family planning services

Covered expenses include charges incurred by *you* for the following:

- *Surgery*, anesthesia and its administration performed by a *health care practitioner's* office for implantable contraceptive devices such as Depo-Provera, Norplant, IUD's, and diaphragms; and
- Nutritional education.

H204260GA

Infertility services

Covered expenses include diagnostic testing that customarily can be performed in a *health care practitioner's* office. They are not procedures, tests or exams that are customarily performed by a specialist or sub-specialist.
H204270GA

Health care practitioner office services

We will pay the following benefits for *covered expenses* incurred by *you* for *health care practitioner* office visit services. *You* must incur the *health care practitioner's* services as the result of a *sickness* or *bodily injury*.

Health care practitioner office visit

Covered expenses include:

- Office visits for the diagnosis and treatment of a *sickness* or *bodily injury*.
- Office visits for prenatal care.
- Office visits for *diabetes self-management training*.
- Diagnostic laboratory and radiology.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

H204400GA 01/16

Health care practitioner services at a retail clinic

We will pay benefits for *covered expenses* incurred by *you* for *health care practitioner* services at a *retail clinic* for a *sickness* or *bodily injury*.
H204450 01/16

COVERED EXPENSES (continued)

Hospital services

We will pay benefits for *covered expenses* incurred by *you* while *hospital confined* or for *outpatient* services. A *hospital confinement* must be ordered by a *health care practitioner*.

For *emergency care* benefits provided in a *hospital*, refer to the "Emergency services" provision of this section.

Hospital inpatient services

Covered expenses include:

- Daily semi-private, ward, intensive care or coronary care *room and board* charges for each day of *confinement.* Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while *confined*.
- Services and supplies, other than *room and board*, provided by a *hospital* while *confined*.
- Services for inpatient care for an appropriate length of stay as determined by a *health care practitioner* for a *covered person*, who is receiving benefits in connection with a mastectomy or lymph node dissection.

Health care practitioner inpatient services when provided in a hospital

Services that are payable as a *hospital* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to *you* while *you* are *hospital confined*.
- *Surgery* performed on an *inpatient* basis. In order for plastic *surgery* to be considered a *covered expense*, it must be for the purpose of improving function by anatomic alterations. If multiple *surgeries* are performed the same day, the *surgeries* will be paid according to the provider contract for the *network provider*.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable *surgery*, each surgeon will be paid according to the provider contract if they are a *network provider*.
- Services of an *assistant surgeon.* The *assistant surgeon* will be paid according to the provider contract if they are a *network provider*.
- Services of a *surgical assistant.* The *surgical assistant* will be paid according to the provider contract if they are a *network provider.*
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.

COVERED EXPENSES (continued)

- Consultation charges requested by the attending *health care practitioner* during a *hospital confinement.* The benefit is limited to one consultation by any one *health care practitioner* per specialty during a *hospital confinement.*

- Services of a pathologist.

- Services of a radiologist.

- Services performed on an emergency basis in a *hospital* if the *sickness* or *bodily injury* being treated results in a *hospital confinement.*

For the purpose of this "Health care practitioner inpatient services when provided in a hospital" provision, provider contract means a written contract with a *network provider* that specifies reimbursement for a *covered expense.*

Hospital outpatient services

Covered expenses include *outpatient* services and supplies, as outlined in the following provisions, provided in a *hospital's outpatient* department.

Covered expenses provided in a *hospital's outpatient* department will not exceed the average semi-private room rate when *you* are in *observation status*.

Hospital outpatient surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with *outpatient surgery*.

Health care practitioner outpatient services when provided in a hospital

Services that are payable as a *hospital* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis. In order for plastic *surgery* to be considered a *covered expense*, it must be for the purpose of improving function by anatomic alterations. If multiple *surgeries* are performed during the same day, the *surgeries* will be paid according to the provider contract for a *network provider*.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable *surgery*, each surgeon will be paid according to the provider contract if they are a *network provider*.

- Services of an *assistant surgeon*. The *assistant surgeon* will be paid according to the provider contract if they are a *network provider*.
- Services of a *surgical assistant*. The *surgical assistant* will be paid according to the provider contract if they are a *network provider*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

For the purpose of this "Health care practitioner outpatient services when provided in a hospital" provision, provider contract means a written contract with a *network provider* that specifies reimbursement for a *covered expense*.

Hospital outpatient non-surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with non-surgical services.

Hospital outpatient advanced imaging

We will pay benefits for *covered expenses* incurred by *you* for *outpatient advanced imaging* in a *hospital's outpatient* department.
H205400GA 01/19

Pregnancy and newborn benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for a pregnancy.

Covered expenses include:

- A minimum stay of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate*.

- If a mother and newborn are discharged prior to the above lengths of stay, coverage shall be provided for up to two follow-up visits, provided that the first such visit shall occur within 48 hours of discharge. Such visits shall be conducted by a physician, a physician's assistant, or a registered nurse with experience and training in maternal and child health nursing. After conferring with the mother, the health care provider shall determine whether the initial visit will be conducted at home or at the office. Thereafter, he or she shall confer with the mother and determined whether a second visit is appropriate and where it shall be conducted. Services include but are not limited to: physician assessment of the newborn, parent education, assistance of the home support system, and the performance of any medically necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services.

- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:

  - *Hospital* charges for *routine nursery care*;
  - The *health care practitioner's* charges for circumcision of the newborn child; and
  - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.

- If the covered newborn must remain in the *hospital* past the mother's *confinement,* services and supplies received for:

  - A *bodily injury* or *sickness*;
  - Care and treatment for premature birth; and
  - Medically diagnosed birth defects and abnormalities.

Covered expenses also include *cosmetic surgery* specifically and solely for:

- Reconstruction due to *bodily injury,* infection or other disease of the involved part; or
- *Congenital anomaly* of a covered *dependent* child that resulted in a *functional impairment*.

The newborn will not be required to satisfy a separate *deductible* and/or *copayment* for *hospital* facility charges for the *confinement* period immediately following birth. A *deductible* and/or *copayment,* if applicable, will be required for any subsequent *hospital admission.*
H205500GA 01/16

Emergency services

We will pay benefits for *covered expenses* incurred by *you* for *emergency care,* including the treatment and stabilization of an emergency medical condition.

Emergency care provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the *network provider* benefit as specified in the "Emergency services" benefit on the "Schedule of Benefits," subject to the *maximum allowable fee*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee*. *You* may be required to pay any amount not paid by *us*. These services are subject to the terms, conditions, limitations, and exclusions of the *master group contract.*

COVERED EXPENSES (continued)

Covered expenses also include *health care practitioner* services for *emergency care*, including the treatment and stabilization of an emergency medical condition, provided in a *hospital* emergency facility. These services are subject to the terms, conditions, limitations, and exclusions of the *master group contract.*

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency care.*
H205700GA 01/18

Ambulance services

We will pay benefits for *covered expenses* incurred by *you* for licensed *ambulance* services to, from or between medical facilities for *emergency care.*

Ambulance services for *emergency care* provided by a *non-network provider* will be covered at the *network provider* benefit, as specified in the "Ambulance services" benefit on the "Schedule of Benefits," subject to the *maximum allowable fee*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee*. *You* may be required to pay any amount not paid by *us.*
H205800 01/18

Ambulatory surgical center services

We will pay benefits for *covered expenses* incurred by *you* for services provided in an *ambulatory surgical center* for the utilization of the facility and ancillary services in connection with *outpatient surgery.*

Health care practitioner outpatient services when provided in an ambulatory surgical center

Services that are payable as an *ambulatory surgical center* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis. In order for plastic *surgery* to be considered a *covered expense*, it must be for the purpose of improving function by anatomic alterations. If multiple *surgeries* are performed during the same day, the *surgeries* will be paid according to the provider contract for a *network provider*.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable *surgery*, each surgeon will be paid according to the provider contract if they are a *network provider*.

- Services of an *assistant surgeon.* The *assistant surgeon* will be paid according to the provider contract if they are a *network provider*.

- Services of a *surgical assistant.* The *surgical assistant* will be paid according to the provider contract if they are a *network provider*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery.*

- Services of a pathologist.

- Services of a radiologist.

For the purpose of this "Health care practitioner outpatient services when provided in an ambulatory surgical center" provision, provider contract means a written contract with a *network provider* that specifies reimbursement for a *covered expense.*
H206000GA 01/19

Durable medical equipment

We will pay benefits for *covered expenses* incurred by *you* for *durable medical equipment* and *diabetes equipment.*

At *our* option, *covered expense* includes the purchase or rental of *durable medical equipment* or *diabetes equipment.* If the cost of renting the equipment is more than *you* would pay to buy it, only the purchase price is considered a *covered expense.* In either case, total *covered expenses* for *durable medical equipment* or *diabetes equipment* shall not exceed its purchase price. In the event *we* determine to purchase the *durable medical equipment* or *diabetes equipment,* any amount paid as rent for such equipment will be credited toward the purchase price.

Repair and maintenance of purchased *durable medical equipment* and *diabetes equipment* is a *covered expense* if:

- Manufacturer's warranty is expired; and
- Repair or maintenance is not a result of misuse or abuse; and
- Maintenance is not more frequent than every six months; and
- Repair cost is less than replacement cost.

Replacement of purchased *durable medical equipment* and *diabetes equipment* is a *covered expense* if:

- Manufacturer's warranty is expired; and
- Replacement cost is less than repair cost; and
- Replacement is not due to lost or stolen equipment, or misuse or abuse of the equipment; or
- Replacement is required due to a change in *your* condition that makes the current equipment non-functional.

H206100 01/18

COVERED EXPENSES (continued)

Hearing aid devices and services

We will pay benefits for *covered expenses* incurred by *covered persons* under the age of 19 who have a hearing loss that has been verified by a *health care practitioner* and a licensed audiologist. Coverage will include one *hearing aid* per hearing impaired ear every 48-months not to exceed $3,000.00 per *hearing aid.*

Covered expenses include the following:

- Initial *hearing aid* evaluation;
- Fitting, dispensing, programming, servicing, repairs;
- Follow-up maintenance, adjustments, ear molds, ear mold impressions; and
- Auditory training, and probe microphone measurements to ensure appropriate gain and output, as well as verifying benefit from the system selected according to acceptable professional standards.

In the event that a *hearing aid* can no longer adequately meet the needs of the *covered person* and the *hearing aid* can no longer be adequately repaired or adjusted, the *hearing aid* shall be replaced.
H206300GA 01/19

Free-standing facility services

Free-standing non-surgical services

We will pay benefits for *covered expenses* for services provided in a *free-standing facility*.

Health care practitioner non-surgical services when provided in a free-standing facility

We will pay benefits for *outpatient* non-surgical services provided by a *health care practitioner* in a *free-standing facility*.

Free-standing facility advanced imaging

We will pay benefits for *covered expenses* incurred by *you* for *outpatient advanced imaging* in a *free-standing facility*.
H206600 01/17

Home health care services

We will pay benefits for *covered expenses* incurred by *you* in connection with a *home health care plan*. All home health care services and supplies must be provided on a part-time or intermittent basis to *you* in conjunction with the approved *home health care plan.*

COVERED EXPENSES (continued)

The "Schedule of Benefits" shows the maximum number of visits allowed by a representative of a *home health care agency*, if any. A visit by any representative of a *home health care agency* of two hours or less will be counted as one visit. Each additional two hours or less is considered an additional visit.

Home health care *covered expenses* include:

- Care provided by a *nurse*;
- Physical, occupational, respiratory or speech therapy;
- Medical social work and nutrition services;
- Charges for services of a home health aide; and
- Medical appliances, equipment and laboratory services.

Home health care *covered expenses* do not include:

- Charges for mileage or travel time to and from the *covered person's* home;
- Wage or shift differentials for any representative of a *home health care agency*;
- Charges for supervision of *home health care agencies*;
- *Custodial care*; or
- The provision or administration of *self-administered injectable drugs*, unless otherwise determined by *us*.

H206700GA 01/18

Hospice services

We will pay benefits for *covered expenses* incurred by *you* for a *hospice care program.* A *health care practitioner* must certify that the *covered person* is terminally ill with a life expectancy of 18 months or less.

If the above criteria is not met, no benefits will be payable under the *master group contract.*

Hospice care benefits are payable as shown on the "Schedule of Benefits" for the following hospice services:

- *Room and board* at a hospice, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for up to eight hours in any one day;
- Counseling for the terminally ill *covered person* and his/her immediate covered *family members* by a licensed:
  - Clinical social worker; or
  - Pastoral counselor.
- Medical social services provided to the terminally ill *covered person* or his/her immediate covered *family members* under the direction of a *health care practitioner*, including:
  - Assessment of social, emotional and medical needs, and the home and family situation; and
  - Identification of the community resources available.

- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health aide services for up to eight hours in any one day; and
- Medical supplies, drugs, and medicines prescribed by a *health care practitioner* for *palliative care*.

Hospice care *covered expenses* do not include:

- A *confinement* not required for acute pain control or other treatment for an acute phase of chronic symptom management;
- Services by volunteers or persons who do not regularly charge for their services;
- Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister; and
- Bereavement counseling services for *family members* not covered under the *master group contract.*

H206800 01/17

Jaw joint benefit

We will pay benefits for *covered expenses* incurred by *you* during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and the skull, subject to the maximum benefit shown on the "Schedule of Benefits." Expenses covered under this jaw joint benefit are not covered under any other provision of this *certificate.*

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation, as necessary;
- Diagnostic x-rays;
- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;
- Diagnostic therapeutic masticatory muscle and temporomandibular joint injections;
- Appliance therapy utilizing an appliance that does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *maximum allowable fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and
- Surgical procedures.

Covered expenses do not include charges for:

- Occlusal analysis; or
- Any irreversible procedure, including but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures and full dentures.

H206900GA 01/19

COVERED EXPENSES (continued)

Physical medicine and rehabilitative services

We will pay benefits for *covered expenses* incurred by *you* for the following physical medicine and/or rehabilitative services for a documented *functional impairment*, pain, or developmental delay or defect as ordered by a *health care practitioner* and performed by a *health care practitioner*:

- Physical therapy services;
- Occupational therapy services;
- Spinal manipulations/adjustments;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;
- Respiratory or pulmonary rehabilitation services; and
- Cardiac rehabilitation services.

The "Schedule of Benefits" shows the maximum number of visits for physical medicine and/or rehabilitative services, if any.
H207000 01/19

Skilled nursing facility services

We will pay benefits for *covered expenses* incurred by *you* for charges made by a *skilled nursing facility* for *room and board* and for services and supplies. *Your confinement* to a *skilled nursing facility* must be based upon a written recommendation of a *health care practitioner*.

The "Schedule of Benefits" shows the maximum length of time for which *we* will pay benefits for charges made by a *skilled nursing facility*, if any.
H207100 01/16

Health care practitioner services when provided in a skilled nursing facility

Services that are payable as a *skilled nursing facility* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to *you* while *you* are *confined* in a *skilled nursing facility*;
- Consultation charges requested by the attending *health care practitioner* during a *confinement* in a *skilled nursing facility*;
- Services of a pathologist; and
- Services of a radiologist.

H207110 01/17

COVERED EXPENSES (continued)

Specialty drugs in a medical place of service

We will pay benefits for *covered expenses* incurred by *you* for *specialty drugs* that are administered in the following medical places of service:

- *Health care practitioner's* office;
- *Free-standing facility*;
- *Urgent care center*;
- Home health care;
- *Hospital*;
- *Skilled nursing facility*;
- *Ambulance*; and
- Emergency room.

Benefits for *specialty drugs* may be subject to *preauthorization* requirements, if any. Please refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*.

Benefits for *specialty drugs* do not include the charge for the actual administration of the *specialty drug*. Payment for the administration of *specialty drugs* is addressed in the "Schedule of Benefits" section of this *certificate*.
H207120 01/18

Urgent care services

We will pay benefits for *covered expenses* incurred by *you* for charges made by an *urgent care center* for *urgent care* services. *Covered expense* also includes *health care practitioner* services for *urgent care* provided at and billed by an *urgent care center*.
H207200 01/18

Additional covered expenses

We will pay benefits for *covered expenses* incurred by *you* based upon the location of the services and the type of provider for:

- Blood and blood plasma, which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.

- Oxygen and rental of equipment for its administration.

- Prosthetic devices and supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices to:

  - Restore the previous level of function lost as a result of a *bodily injury* or *sickness*; or
  - Improve function caused by a *congenital anomaly*.

COVERED EXPENSES (continued)

Covered expense for prosthetic devices includes repair or replacement, if not covered by the manufacturer, and if due to:

- A change in the *covered person's* physical condition causing the device to become non-functional; or
- Normal wear and tear.

- Cochlear implants, when approved by *us,* for a *covered person* with bilateral severe to profound sensorineural deafness.

  Replacement or upgrade of a cochlear implant and its external components may be a *covered expense* if:

  - The existing device malfunctions and cannot be repaired;
  - Replacement is due to a change in the *covered person's* condition that makes the present device non-functional; or
  - The replacement or upgrade is not for cosmetic purposes.

- Orthotics used to support, align, prevent, or correct deformities.

  Covered expense does not include:

  - Replacement orthotics;
  - Dental braces; or
  - Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.

- The following special supplies, dispensed up to a 30-day supply, when prescribed by *your* attending *health care practitioner*:

  - Surgical dressings;
  - Catheters;
  - Colostomy bags, rings and belts; and
  - Flotation pads.

- The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.

- Dental treatment only if:

  - The charges are incurred for treatment of a *dental injury* to a *sound natural tooth*;
  - The treatment begins within 90 days after the date of the *dental injury*; and
  - The treatment is completed within 12 months after the date of the *dental injury*.

  However, benefits will be paid only for the least expensive service that will, in *our* opinion, produce a professionally adequate result.

COVERED EXPENSES (continued)

- Certain oral surgical operations as follows:

  - Excision of partially or completely impacted teeth;

  - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;

  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth and related biopsy of bone, tooth, or related tissues when such conditions require pathological examinations;

  - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;

  - Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

  - Reduction of fractures and dislocation of the jaw;

  - External incision and drainage of cellulitis and abscess;

  - Incision and closure of accessory sinuses, salivary glands or ducts;

  - Frenectomy (the cutting of the tissue in the midline of the tongue); and

  - Orthognathic surgery for a *congenital anomaly*, *bodily injury* or *sickness* causing a *functional impairment*.

- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:

  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.

- Reconstructive *surgery* resulting from:

  - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
  - A *congenital anomaly* that resulted in a *functional impairment*.

  Expenses for reconstructive *surgery* due to a psychological condition are <u>not</u> considered a *covered expense*, unless the condition(s) described above are also met.

COVERED EXPENSES (continued)

- Enteral formulas, nutritional supplements and low protein modified foods for use at home by a *covered person* that are prescribed or ordered by a *health care practitioner* and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

- The following *habilitative services*, as ordered and performed by a *health care practitioner*, for a *covered person*, with a developmental delay or defect or *congenital anomaly*:

  - Physical therapy services;
  - Occupational therapy services;
  - Spinal manipulations/adjustments;
  - Speech therapy or speech pathology services; and
  - Audiology services.

  Habilitative services apply toward the "Physical medicine and rehabilitative services" maximum number of visits specified in the "Schedule of Benefits."

H207420GA 01/19

- *Telehealth* and *telemedicine* services for the diagnosis and treatment of a *sickness* or *bodily injury*. *Telehealth* or *telemedicine* services must be:

  - Services that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner*;
  - Provided to a *covered person* at the *originating site*; and
  - Provided by a *health care* practitioner at the *distant site*.

  Telehealth and *telemedicine* services must comply with:

  - Federal and state licensure requirements;
  - Accreditation standards; and
  - Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.

- Routine costs for a *covered person* participating in an approved Phase I, II, III or IV clinical trial.

  Routine costs include health care services that are otherwise a *covered expense* if the *covered person* were not participating in a clinical trial.

  Routine costs do not include services or items that are:

  - *Experimental*, *investigational* or *for research purposes*;
  - Provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
  - Inconsistent with widely accepted and established standards of care for a diagnosis.

  The *covered person* must be eligible to participate in a clinical trial according to the trial protocol and:

  - Referred by a *health care practitioner*; or
  - Provide medical and scientific information supporting their participation in the clinical trial is appropriate.

COVERED EXPENSES (continued)

For the routine costs to be considered a *covered expense*, the approved clinical trial must be a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life threatening condition or disease and is:

- Federally funded or approved by the appropriate federal agency;
- The study or investigation is conducted under an investigational new drug application reviewed by the Federal Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- *Medically necessary* outpatient self-management training, including medical nutrition therapy, when prescribed by a *health care practitioner*, for the treatment of:

  - Insulin-dependent diabetes;
  - Insulin-using diabetes;
  - Gestational diabetes; or
  - Non-Insulin-using diabetes.

  Outpatient self-management training and education must be provided by a certified, registered, or licensed health care professional, which has expertise in diabetes. *Covered expenses* for *outpatient* self-management training and education will conform to current standards established by the American Diabetes Association.

H207422GA 01/18

- Scientifically proven bone density testing for the prevention, diagnosis, and treatment of osteoporosis for *covered persons*, who are qualified individuals. A qualified individual means a *covered person*, who is an:

  - Estrogen-deficient woman or individual at clinical risk of osteoporosis as determined directly or indirectly by a *health care practitioner*, and who is considering treatment;
  - Individual with osteoporotic vertebral abnormalities;
  - Individual with primary hyperparathyroidism; or
  - Individual receiving long-term glucocorticoid therapy;
  - Individual being monitored directly or indirectly by a *health care practitioner* to assess the response to or efficacy of approved osteoporosis drug therapies.

H207425GA 01/19

- General anesthesia and associated services from a *hospital*, *free-standing facility*, or *health care treatment facility* in conjunction with dental care provided by a *health care practitioner* when any of the following are met:

  - A *covered person* is a *dependent* child seven years of age or younger;
  - A *covered person* is developmentally disabled;
  - A successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition; or
  - A *covered person* has sustained extensive facial or dental trauma.

H207430GA

- Contraceptive implant systems and devices approved by the United States Food and Drug Administration for contraceptive purposes.

H207435GA

COVERED EXPENSES - CLINICAL TRIALS

Definitions

The following definitions are used exclusively in this provision:
H3032010GA 09/09

Cancer screenings and examinations means screenings and examinations for cancer in accordance with the most recently published guidelines and recommendations established by any of the following:

- American College of Physicians;
- American College of Obstetricians and Gynecologists; or
- American Academy of Pediatricians.

H3032020GA

Qualified clinical trial means a trial that must be a trial that is approved by one of the following:

- A Cooperative Group or one of the National Institutes of Health;
- The United States Food and Drug Administration, in the form of an investigational new drug application;
- The United States Department of Defense;
- The United States Veterans' Administration;
- The National Cancer Institute; or
- An Institutional Review Board of any accredited school of medicine, nursing or pharmacy in the State of Georgia.

H3032030GA

Routine patient care costs means those costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered under the *master group contract* if those drugs, items, devices and services were not provided in connection with an approved *qualified clinical trial* program, including the following:

- Health care services includes routine care that would otherwise be a *covered expense* if the *covered person* were not participating in a *qualified clinical trial*;

- Health care services required solely for the provision of the investigational drug, item, device or service;

- Health care services required for the clinically appropriate monitoring of the investigational item or service;

- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device or service; and

- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

COVERED EXPENSES - CLINICAL TRIALS (continued)

Routine patient care costs do not include the costs associated with the provision of any of the following:

- Drugs that are *experimental, investigational* or for research purposes and devices that have not been approved by the United States Food and Drug Administration associated with the *qualified clinical trial*;
- Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that *you* may require as a result of the treatment being provided for purposes of the *qualified clinical trial.* Reimbursement for travel and lodging accommodations is only applicable when it is otherwise available as a benefit in the *certificate.*
- Any item or service that is provided solely to satisfy data collection and analysis that is not directly used in the clinical management of the *covered person*;
- Health care services which, except for the fact they are not being provided in a *qualified clinical trial*, are otherwise specifically excluded from coverage under this *master group contract*;
- Health care services which are inconsistent with widely accepted and established standards of care or diagnosis; or
- Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

H3032040GA 01/18

Participation in a qualified clinical trial

Notwithstanding any exclusion or provision in the *master group contract, we* will pay benefits for *routine patient care costs* for *you* if *you* are eligible to participate according to the trial protocol and:

- Referred by a *health care practitioner*; or
- Provide medical and scientific information supporting their participation in the *qualified clinical trial* is appropriate.

H3032045GA 01/18

Qualified clinical trials routine patient care costs benefit

Notwithstanding any exclusion or provision in the *master group contract, we* will pay benefits for *routine patient care costs* for *you* if *you* are:

- A Georgia resident covered by *us*;
- Diagnosed with cancer; and
- Accepted into a Phase I, Phase II, Phase III or Phase IV *qualified clinical trial* for cancer or a life threatening condition.

COVERED EXPENSES - CLINICAL TRIALS (continued)

Covered expenses for *routine patient care costs* associated with a *qualified clinical trial* will be covered the same as for any other *sickness*.
H3032050GA 11/12

Cancer screenings and examinations benefit

Notwithstanding any exclusion or provision in the *master group contract*, *we* will pay benefits for *cancer screenings and examinations*.

Covered expenses for *cancer screenings and examinations* will be covered the same as *sickness*.
H3032060GA 09/09

COVERED EXPENSES - BEHAVIORAL HEALTH

This "Covered Expenses – Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services* and *chemical dependency* services under the *master group contract.* Benefits for *mental health services* and *chemical dependency* services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Behavioral Health." Refer to the "Schedule of Benefits" for any service not specifically listed in the "Schedule of Benefits – Behavioral Health." Benefits are subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate.* All terms and provisions of the *master group contract* apply, including the *preauthorization* specified in this *certificate.*
H208000GA 01/18

Acute inpatient services

We will pay benefits for *covered expenses* incurred by *you* due to an *admission* or *confinement* for *acute inpatient services* for *mental health services* and *chemical dependency* services provided in a *hospital* or *health care treatment facility*.
H208100 01/18

Partial hospitalization services

We will pay benefits for *covered expenses* incurred by *you* for *partial hospitalization* for *mental health services* and *chemical dependency* services in a *hospital* or *health care treatment facility*.
H208400 01/16

Residential treatment facility services

We will pay benefits for *covered expenses* incurred by *you* due to an *admission* or *confinement* for *mental health services* and *chemical dependency* services provided in a *residential treatment facility*.
H208410 01/19

Acute inpatient, partial hospitalization and residential treatment facility health care practitioner services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services* and *chemical dependency* services provided by a *health care practitioner,* including *telehealth* or *telemedicine,* in a *hospital, health care treatment facility* or *residential treatment facility.*

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Emergency services

We will pay benefits for *covered expenses* incurred by *you* for *emergency care*, including the treatment and stabilization of an emergency condition for *mental health services* and *chemical dependency* services.

Emergency care provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the *network provider* benefit as specified in the "Emergency services" benefit on the "Schedule of Benefits – Behavioral Health," subject to the *maximum allowable fee*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee*. *You* may be required to pay any amount not paid by *us.* These services are subject to the terms, conditions, limitations, and exclusions of the *master group contract.*

Covered expenses also include *health care practitioner* services for *emergency care*, including the treatment and stabilization of an emergency condition, provided in a *hospital* emergency facility. These services are subject to the terms, conditions, limitations, and exclusions of the *master group contract.*

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency care.*
H208425GA 01/19

Urgent care services

We will pay benefits for *covered expenses* incurred by *you* in an *urgent care center* for *mental health services* and *chemical dependency* services. *Covered expenses* also include *health care practitioner* services for *urgent care* provided at and billed by an *urgent care center*.
H208450 01/18

Outpatient services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services* and *chemical dependency* services, including services in a *health care practitioner* office or *retail clinic, outpatient* therapy, *outpatient* services provided as part of an *intensive outpatient program,* and other *outpatient* services, while not *confined* in a *hospital, residential treatment facility* or *health care treatment facility*.
H208500 01/19

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Skilled nursing facility services

We will pay benefits for *behavioral health covered expenses* incurred by *you* for charges made by a *skilled nursing facility* for *room and board* and for services and supplies. *Your confinement* to a *skilled nursing facility* must be based upon a written recommendation of a *health care practitioner*.

Covered expenses also include *health care practitioner* services for *behavioral health* during *your confinement* in a *skilled nursing facility.*
H208525 01/19

Home health care services

We will pay benefits for *covered expenses* incurred by *you,* in connection with a *home health care plan,* for *mental health services* and *chemical dependency* services. All home health care services and supplies must be provided on a part-time or intermittent basis to *you* in conjunction with the approved *home health care plan.*

Home health care *covered expenses* include services provided by a *health care practitioner* who is a *behavioral health* professional, such as a counselor, psychologist or psychiatrist.

Home health care *covered expenses* do not include:

- Charges for mileage or travel time to and from the *covered person's* home;
- Wage or shift differentials for any representative of a *home health care agency*;
- Charges for supervision of *home health care agencies*;
- *Custodial care*; or
- The provision or administration of *self-administered injectable drugs*, unless otherwise determined by *us*.

H208550GA 01/18

Specialty drugs in a medical place of service

We will pay benefits for *covered expenses* incurred by *you* for *specialty drugs* that are administered in the following medical places of service:

- *Health care practitioner's* office;
- *Free-standing facility*;
- *Urgent care center*;
- Home health care;
- *Hospital*;
- *Skilled nursing facility*;
- *Residential treatment facility*;
- *Ambulance*; and
- Emergency room.

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Benefits for *specialty drugs* may be subject to *preauthorization* requirements, if any. Please refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*.

Benefits for *specialty drugs* do not include the charge for the actual administration of the *specialty drug*. Payment for the administration of *specialty drugs* is addressed in the "Schedule of Benefits" section of this *certificate*.
H208600 01/19

Autism spectrum disorders

Covered expenses for autism spectrum disorder are payable the same as any other *behavioral health sickness* based upon location of services and the type of provider.
H208700 01/18

COVERED EXPENSES - TRANSPLANT SERVICES

This "Covered Expenses – Transplant Services" section describes the services that will be considered *covered expenses* for transplant services under the *master group contract.* Benefits for transplant services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Transplant Services," subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate* for transplant services not covered by the *master group contract.* All terms and provisions of the *master group contract* apply. *H210000 01/18*

Transplant covered expenses

We will pay benefits for *covered expenses* incurred by *you* for a transplant that is preauthorized and approved by *us*. *We* must be notified of the initial transplant evaluation and given a reasonable opportunity to review the clinical results to determine if the transplant will be covered. *You* or *your health care practitioner* must contact *our* Transplant Management Department by calling the Customer Service number on *your* ID card when in need of a transplant. *We* will advise *your health care practitioner* once coverage of the requested transplant is approved by *us.* Benefits are payable only if the transplant is approved by *us.*

Covered expenses for a transplant include pre-transplant services, transplant inclusive of any integral chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation for or in connection with only the following procedures:

- Heart;
- Lung(s);
- Liver;
- Kidney;
- *Bone marrow*;
- Intestine;
- Pancreas;
- Auto islet cell;
- Any combination of the above listed transplants; and
- Any transplant not listed above required by state or federal law.

Multiple transplantations performed simultaneously are considered one transplant *surgery.*

Corneal transplants and porcine heart valve implants are tissues, which are considered part of regular plan benefits and are subject to other applicable provisions of the *master group contract.*

The following are *covered expenses* for an approved transplant and all related complications:

- *Hospital* and *health care practitioner* services.

COVERED EXPENSES - TRANSPLANT SERVICES (continued)

- Acquisition for transplants and associated donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition. Donor costs for post-discharge services and treatment of complications for or in connection with acquisition for an approved transplant will not exceed the transplant treatment period of 365 days from the date of *hospital* discharge following acquisition.

- Direct, non-medical costs for:

  - The *covered person* receiving the transplant, if he or she lives more than 100 miles from the transplant facility; and
  - One designated caregiver or support person (two, if the *covered person* receiving the transplant is under 18 years of age), if they live more than 100 miles from the transplant facility.

  Direct, non-medical costs include:

  - Transportation to and from the *hospital* where the transplant is performed; and
  - Temporary lodging at a prearranged location when requested by the *hospital* and approved by *us*.

  All direct, non-medical costs for the *covered person* receiving the transplant and the designated caregiver(s) or support person(s) are payable, as specified in the "Schedule of Benefits – Transplant Services" section in this *certificate*.

Covered expenses for post-discharge services and treatment of complications for or in connection with an approved transplant are limited to the transplant treatment period of 365 days from the date of *hospital* discharge following transplantation of an approved transplant received while *you* were covered by *us*. After this transplant treatment period, regular plan benefits and other provisions of the *master group contract* are applicable.
H210200 01/19

COVERED EXPENSES - PHARMACY SERVICES

This "Covered Expenses – Pharmacy Services" section describes *covered expenses* under the *master group contract* for *prescription* drugs, including *specialty drugs,* dispensed by a *pharmacy*. Benefits are subject to applicable *cost share* shown on the "Schedule of Benefits – Pharmacy Services" section of this *certificate.*

Refer to the "Limitations and Exclusions," "Limitations and Exclusions – Pharmacy Services," "Glossary" and "Glossary – Pharmacy Services" sections in this *certificate.* All terms and provisions of the *master group contract* apply, including *prior authorization* requirements specified in the "Schedule of Benefits – Pharmacy Services" of this *certificate.*

Coverage description

We will cover *prescription* drugs that are received by *you* under this "Covered Expenses – Pharmacy Services" section. Benefits may be subject to *dispensing limits, prior authorization* and *step therapy* requirements, if any.

Covered *prescription* drugs are:

- Drugs, medicines or medications and *specialty drugs* that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications and *specialty drugs* included on *our drug list.*
- Insulin and *diabetes supplies*.
- *Self-administered injectable drugs* approved by *us.*
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*).
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us.*
- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

Notwithstanding any other provisions of the *master group contract, we* may decline coverage or, if applicable, exclude from the *drug list* any and all *prescriptions* until the conclusion of a review period not to exceed six months following FDA approval for the use and release of the *prescriptions* into the market.

COVERED EXPENSES - PHARMACY SERVICES (continued)

Prescription drug coverage restrictions

If *we* determine *you* are using *prescription* drugs in a potentially abusive, excessive or harmful manner, *your* coverage of *pharmacy* services may be limited in one or more of the following ways:

- By restricting *your pharmacy* services to a single *network pharmacy* store or physical location of *your* choice;
- By restricting *your specialty pharmacy* services to a specific *specialty pharmacy* of *your* choice, if the *network pharmacy* store or physical location for *pharmacy* services is unable to provide or is not contracted with *us* to provide covered *specialty pharmacy* services; and
- By restricting all of *your prescriptions* to be prescribed by a specific *network health care practitioner* of *your* choice.

When *we* determine it is necessary to restrict *your pharmacy* services, only *prescriptions* obtained from the specific *network pharmacy* store or physical location or *specialty pharmacy* will be eligible to be considered *covered expenses*. Additionally, only *prescriptions* prescribed by the specific *network health care practitioner* will be eligible to be considered *covered expenses*.

About our drug list

Prescription drugs, medicines or medications, including *specialty drugs* and *self-administered injectable drugs* prescribed by *health care practitioners* and covered by *us* are specified on *our* printable *drug list.* The *drug list* identifies categories of drugs, medicines or medications by levels. It also indicates *dispensing limits, specialty drug* designation and any applicable *prior authorization* or *step therapy* requirements. This information is reviewed on a regular basis by a Pharmacy and Therapeutics committee made up of physicians and *pharmacists*. Placement on the *drug list* does not guarantee *your health care practitioner* will prescribe that *prescription* drug, medicine or medication for a particular medical condition. *You* can obtain a copy of *our drug list* by visiting *our* Website at www.humana.com or calling the customer service telephone number on *your* identification card.

Access to non-formulary contraceptives

A *covered person* may gain access to non-formulary contraceptive drugs with no cost-sharing when a *health care practitioner* recommends and determines that a particular method of contraception or FDA-approved contraceptive item is *medically necessary*.

Access to non-formulary drugs

A drug not included on *our drug list* is a non-formulary drug. If a *health care practitioner* prescribes a clinically appropriate non-formulary drug, *you* can request coverage of the non-formulary drug through a standard exception request or an expedited exception request. If *you* are dissatisfied with *our* decision of an exception request, *you* have the right to the non-formulary drug appeal procedures.

COVERED EXPENSES - PHARMACY SERVICES (continued)

Pharmacy standard exception request

A standard exception request for coverage of a clinically appropriate non-formulary drug may be initiated by *you*, *your* appointed representative, or the prescribing *health care practitioner* by calling the customer service number on *your* identification card, in writing, or electronically by visiting *our* Website at www.humana.com. *We* will respond to a standard exception request no later than 72 hours after the receipt date of the request.

As part of the standard exception request, the prescribing *health care practitioner* should include an oral or written statement that provides justification to support the need for the prescribed non-formulary drug to treat the *covered person's* condition, including a statement that all covered drugs on the *drug list* on any tier:

- Will be or have been ineffective;
- Would not be as effective as the non-formulary drug; or
- Would have adverse effects.

If *we* grant a standard exception request to cover a prescribed, clinically appropriate non-formulary drug, *we* will cover the prescribed non-formulary drug for the duration of the *prescription*, including refills. Any applicable *cost share* for the *prescription* will apply toward the *out-of-pocket limit*.

If *we* deny a standard exception request, *you* have the right to appeal *our* decision as outlined in the "Non-formulary drug appeal procedures" provision in this section.

Pharmacy expedited exception request

An expedited exception request for coverage of a clinically appropriate non-formulary drug based on exigent circumstances may be initiated by *you*, *your* appointed representative, or *your* prescribing *health care practitioner* by calling the customer service number on *your* identification card, in writing, or electronically by visiting *our* Website at www.humana.com. *We* will respond to an expedited exception request within 24 hours of receipt of the request. An exigent circumstance exists when a *covered person* is:

- Suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function; or
- Undergoing a current course of treatment using a non-formulary drug.

As part of the expedited review request, the prescribing *health care practitioner* should include an oral or written:

- Statement that an exigent circumstance exists and explain the harm that could reasonably be expected to the *covered person* if the requested non-formulary drug is not provided within the timeframes of the standard exception request; and

- Justification supporting the need for the prescribed non-formulary drug to treat the *covered person's* condition, including a statement that all covered drugs on the drug list on any tier:

- Will be or have been ineffective;
- Would not be as effective as the non-formulary drug; or
- Would have adverse effects.

If *we* grant an expedited exception request to cover a prescribed, clinically appropriate non-formulary drug based on exigent circumstances, *we* will provide access to the prescribed non-formulary drug:

- Without unreasonable delay; and
- For the duration of the exigent circumstance.

Any applicable *cost share* for the *prescription* will apply toward the *out-of-pocket limit*.

If *we* deny an expedited exception request, *you* have the right to appeal *our* decision, as outlined in the "Non-formulary drug appeal procedures" provision in this section.

Non-formulary drug appeal procedures

If *we* deny an exception request to cover a non-formulary drug, *you*, *your* appointed representative, or *your* prescribing *health care practitioner* have the right to appeal *our* decision to an external independent review organization. Refer to the exception request decision letter for instructions or call the customer service number on *your* identification card.

The decision by the external independent review organization to either uphold or reverse the denial of the original exception request will be provided orally or in writing to *you*, *your* appointed representative, or the prescribing *health care practitioner* no later than:

- 24 hours after receipt of an external exception review request if the original exception request was expedited.
- 72 hours after receipt of an external exception review request if the original exception request was standard.

If the external independent review organization grants the external exception request, *we* will cover the prescribed, clinically appropriate non-formulary drug for *you* for:

- The duration of the *prescription*, including refills, when the original request was a standard exception request.
- The duration of the exigent circumstance when the original request was an expedited exception request.

Any applicable *cost share* for the *prescription* will apply toward the *out-of-pocket limit*.
H210900 01/19

LIMITATIONS AND EXCLUSIONS

These limitations and exclusions apply even if a *health care practitioner* has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent *your health care practitioner* from providing or performing the procedure, treatment or supply. However, the procedure, treatment or supply will not be a *covered expense.*

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

- Treatments, services, supplies or *surgeries* that are not *medically necessary*, except *preventive services*.

- A *sickness* or *bodily injury* arising out of, or in the course of, any employment for wage, gain or profit. This exclusion applies whether or not *you* have Workers' Compensation coverage.

- Care and treatment given in a *hospital* owned, or run, by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their *dependents* are not excluded.

H211600 01/19

- Any service furnished while *you* are *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *sickness* or *bodily injury*.

- Any service *you* would not be legally required to pay for in the absence of this coverage.

- *Sickness* or *bodily injury* for which *you* are in any way paid or entitled to payment or care and treatment by or through a government program. This does not include Medicaid benefits.

- Any service not ordered by a *health care practitioner*.

- Services provided to *you*, if *you* do not comply with the *master group contract's* requirements. These include services:

  - Not provided by a *network provider*, unless required for *emergency care*;
  - Received in an emergency room, unless required because of *emergency care*;
  - Which require *preauthorization* if *preauthorization* was not obtained.

H212100GA 01/18

- Private duty nursing.

- Services rendered by a standby physician, *surgical assistant* or *assistant surgeon* unless *medically necessary*.

- Any service that is not rendered by the billing provider.

- Any service not substantiated in the medical records of the billing provider.

LIMITATIONS AND EXCLUSIONS (continued)

- Education, or training, except for *diabetes self-management training* and *habilitative services*.

- Educational or vocational, therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.

H212600 01/19

- Services provided by a *covered person's family member*.

- *Ambulance* services for routine transportation to, from or between medical facilities and/or a *health care practitioner's* office.

- Any drug, biological product, device, medical treatment, or procedure which is *experimental, investigational* or *for research purposes.*

- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner*, dietary supplements, and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

- Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription*, except for *preventive services*.

H213100 01/19

- Immunizations required for foreign travel for a *covered person* of any age.

- Growth hormones, except as otherwise specified in the pharmacy services sections of this *certificate.*

- *Prescription* drugs and *self-administered injectable* drugs, except as specified in the "Covered Expenses – Pharmacy Services" section in this *certificate* or unless administered to *you*:

  - While an *inpatient* in a *hospital, skilled nursing facility, health care treatment facility* or *residential treatment facility*;
  - By the following, when deemed appropriate by *us*:

    - A *health care practitioner*:

      - During an office visit; or
      - While an *outpatient*; or

    - A *home health care agency* as part of a covered *home health care plan*.

H213600GA 01/16

LIMITATIONS AND EXCLUSIONS (continued)

- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for *hearing aids* for *covered persons* under the age of 19 and cochlear implants as otherwise stated in this *certificate*.

- Services received in an emergency room, unless required because of *emergency care*.

- Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *health care practitioner* when there is no cause for an emergency *admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday.

- *Hospital inpatient* services when *you* are in *observation status*.

- *Infertility services* or reversal of elective sterilization.

- In vitro fertilization regardless of the reason for treatment.

H214000 01/19

- Services for or in connection with a transplant if:

  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by *us*.

  - *We* do not approve coverage for the transplant, based on *our* established criteria.

  - Expenses are eligible to be paid under any private or public research fund, government program except *Medicaid*, or another funding program, whether or not such funding was applied for or received.

  - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *master group contract*.

  - The expense relates to the donation or acquisition of an organ for a recipient who is not covered by *us*.

  - The expense relates to donor costs that are payable in whole or in part by any other group plan, insurance company, organization, or person other than the donor's family or estate.

  - The expense relates to a transplant performed outside of the United States and any care resulting from that transplant.

- Services provided for:

  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Biliary lithotripsy;
  - Sleep therapy;
  - Light treatments for Seasonal Affective Disorder (S.A.D.);

LIMITATIONS AND EXCLUSIONS (continued)

- Immunotherapy for food allergy;
- Prolotherapy; or
- Sensory integration therapy.

- *Cosmetic surgery* and cosmetic services or devices.

- Hair prosthesis, hair transplants or implants and wigs.

H214300 01/19

- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any *oral surgery*, *endodontic services* or *periodontics*, implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *sickness* unless otherwise stated in this *certificate.*

- The following types of care of the feet:

  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable or unbalanced feet;
  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses, or hyperkeratoses;
  - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
  - The cutting of toenails, except the removal of the nail matrix;
  - Heel wedges, lifts, or shoe inserts; and
  - Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or hammer toe.

- *Custodial care* and *maintenance care*.

- Any loss contributed to, caused by:

  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any conflict involving armed forces of any authority.

- Services relating to a *sickness* or *bodily injury as a result of:*

  - Engagement in an illegal profession or occupation; or
  - Commission of or an attempt to commit a criminal act.

  This exclusion does not apply to any *sickness* or *bodily injury* resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

H214800 01/19

- Expenses for any membership fees or program fees, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or surgical programs and any materials or products related to these programs.

- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery.*

LIMITATIONS AND EXCLUSIONS (continued)

- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *health care practitioner*) and certain medical devices including, but not limited to:
  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
  - Medical equipment including:
    - Blood pressure monitoring devices, unless prescribed by a *health care practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;
    - PUVA lights; and
    - Stethoscopes;
  - Communication systems, telephone, television or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment.*
- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
  - The American Academy of Allergy and Immunology; or
  - The Department of Health and Human Services or any of its offices or agencies.
- Lodging accommodations or transportation.

H215200 01/19

- Communications or travel time.
- Bariatric *surgery*, any services or complications related to bariatric *surgery*, and other weight loss products or services.

LIMITATIONS AND EXCLUSIONS (continued)

- Elective medical or surgical abortion unless:

  - The pregnancy would endanger the life of the mother; or
  - The pregnancy is a result of rape or incest.

- *Alternative medicine*.

H215700GA 01/18

- Acupuncture, unless:

  - The treatment is *medically necessary*, appropriate and is provided within the scope of the acupuncturist's license; and
  - *You* are directed to the acupuncturist for treatment by a licensed physician.

- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.

- Services of a midwife, unless the midwife is licensed.

- Vision examinations or testing for the purposes of prescribing corrective lenses.

- Orthoptic/vision training (eye exercises).

- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.

- The purchase or fitting of eyeglasses or contact lenses, except as the result of an *accident* or following cataract *surgery* as stated in this *certificate*.

H216100GA 01/16

- Services and supplies which are:

  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

- Marriage counseling.

- Expenses for employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.

- Expenses for care and treatment of non-covered procedures or services.

H216500GA 11/12

- Expenses for treatment of complications of non-covered procedures or services.

- Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *master group contract.*

LIMITATIONS AND EXCLUSIONS (continued)

- Any care, treatment, services, equipment or supplies received outside of the *service area*:

  - If *you* could have reasonably foreseen or anticipated their need prior to departure from the *service area*; and
  - Which are not authorized by *us* or to the extent they exceed the *maximum allowable fee.*

- *Pre-surgical/procedural testing* duplicated during a *hospital confinement.*

H216925GA 01/16

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

This "Limitations and Exclusions – Pharmacy Services" section describes the limitations and exclusions under the *master group contract* that apply to *prescription* drugs, including *specialty drugs,* dispensed by a *pharmacy*. Please refer to the "Limitations and Exclusions" section of this *certificate* for additional limitations.

These limitations and exclusions apply even if a *health care practitioner* has prescribed a medically appropriate service, treatment, supply, or *prescription.* This does not prevent *your health care practitioner* or *pharmacist* from providing the service, treatment, supply, or *prescription.* However, the service, treatment, supply, or *prescription* will not be a *covered expense*.

Unless specifically stated otherwise, no benefit will be provided for, or on account of, the following items:

- *Legend drugs,* which are not deemed *medically necessary* by *us.*
- *Prescription* drugs not included on the *drug list.*
- Any amount exceeding the *default rate.*
- *Specialty drugs* for which coverage is not approved by *us.*
- Drugs not approved by the FDA.
- Any drug prescribed for intended use other than for:
  - Indications approved by the FDA; or
  - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a *sickness* or *bodily injury* not covered under the *master group contract.*
- Any drug, medicine or medication that is either:
  - Labeled "Caution-limited by federal law to investigational use;" or
  - *Experimental, investigational* or *for research purposes,*

  even though a charge is made to *you.*
- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
  - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *self-administered injectable drugs*, whose coverage is approved by *us*);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the "Covered Expenses" section of the *certificate* for coverage of low protein modified foods.

- Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.

- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Anabolic steroids.

- Any drug used for the purpose of weight loss.

- Any drug used for cosmetic purposes, including, but not limited to:

  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents.

- Any drug or medicine that is lawfully obtainable without a *prescription* (over-the-counter drugs):

  - Insulin; and
  - Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Compounded drugs that:

  - Are prescribed for a use or route of administration that is not FDA approved or compendia supported;
  - Are prescribed without a documented medical need for specialized dosing or administration;
  - Only contain ingredients that are available over-the-counter;
  - Only contain non-commercially available ingredients; or
  - Contain ingredients that are not FDA approved, including bulk compounding powders.

- Abortifacients (drugs used to induce abortions).

- *Infertility services* including medications.

- Any drug prescribed for impotence and/or sexual dysfunction.

- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- The administration of covered medication(s).

- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided on an *inpatient* basis by the facility. *Inpatient* facilities include, but are not limited to:

  - *Hospital*;
  - *Skilled nursing facility*; or
  - Hospice facility.

- Injectable drugs, including, but not limited to:

  - Immunizing agents, unless for *preventive services* determined by *us* to be dispensed by or administered in a *pharmacy*;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* or *step therapy* is not obtained from *us*.

- *Prescription* fills or refills:

  - In excess of the number specified by the *health care practitioner*; or
  - Dispensed more than one year from the date of the original order.

- Any portion of a *prescription* fill or refill that exceeds a 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.

- Any portion of a *prescription* fill or refill that exceeds a 30-day supply when received from a retail *pharmacy* that does not participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.

- Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Any portion of a *prescription* fill or refill that:
  - Exceeds *our* drug-specific *dispensing limit*;
  - Is dispensed to a *covered person*, whose age is outside the drug-specific age limits defined by *us*;
  - Is refilled early, as defined by *us*; or
  - Exceeds the duration-specific *dispensing limit*.
- Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by *you*:
  - Before becoming covered; or
  - After the date *your* coverage has ended.
- Any costs related to the mailing, sending or delivery of *prescription* drugs.
- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you.*
- Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices.
- Treatment for onychomycosis (nail fungus).
- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.
- *Prescriptions* filled at a *non-network pharmacy*, except for *prescriptions* required during an emergency.

H216900GA 01/18

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

The *employee* who lives or works in the *service area* is eligible for coverage on the date:

- The eligibility requirements are satisfied as stated in the Employer Group Application, or as otherwise agreed to by the *group plan sponsor* and *us*; and
- The *employee* is in an *active status.*

H217000 01/19

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child;
- The date of placement of the child for the purpose of adoption by the *employee*, or the date the child is legally adopted by the *employee*, whichever occurs first;
- The date the power of attorney is signed and notarized that authorizes grandparents and great grandparents the authority to act on behalf of a dependent grandchild until a copy of a revocation of the power of attorney is received; or
- The date specified in a Qualified Medical Child Support Order (QMCSO), or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

The *employee* may cover his or her *dependents* only if the *employee* is also covered.

A *dependent* child who resides outside of the *service area* is eligible for coverage as a *dependent.* Out-of-area coverage, however, is limited to *emergency care* and *urgent care* services unless additional coverage is provided by addenda. To be covered, all other care, including follow-up care for *emergency care* and *urgent care* services, must be obtained in the *service area* under the direction of a *network health care practitioner.*
H217100GA 01/16

Enrollment

Employees and *dependents* eligible for coverage under the *master group contract* may enroll for coverage as specified in the enrollment provisions outlined below.
H217300 04/09

ELIGIBILITY AND EFFECTIVE DATES (continued)

Employee enrollment

The *employee* must enroll, as agreed to by the *group plan sponsor* and *us*, within 31 days of the *employee's eligibility date* or within the time period specified in the "Special enrollment" provision.

The *employee* is a *late applicant* if enrollment is requested more than 31 days after the *employee's eligibility date* or later than the time period specified in the "Special enrollment" provision. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

We reserve the right to require an eligible *employee* to submit evidence of health status. No eligible *employee* will be refused enrollment or charged a different premium than other *group* members based on *health status-related factors. We* will administer this provision in a non-discriminatory manner.
H217400 01/19

Dependent enrollment

If electing *dependent* coverage, the *employee* must enroll eligible *dependents*, as agreed to by the *group plan sponsor* and *us*, within 31 days of the *dependent's eligibility date* or within the time period specified in the "Special enrollment" provision.

The *dependent* is a *late applicant* if enrollment is requested more than 31 days after the *dependent's eligibility date* or later than the time period specified in the "Special enrollment" provision. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

We reserve the right to require an eligible *dependent* to submit evidence of health status. No eligible *dependent* will be refused enrollment or charged a different premium that other *group* members based on *health status related factors. We* will administer this provision in a non-discriminatory manner.
H217500 01/19

Newborn and adopted dependent enrollment

A newborn *dependent* will be automatically covered from the date of birth to 31 days of age. An adopted *dependent* will be automatically covered from the date of adoption or placement of the child with the *employee* for the purpose of adoption, whichever occurs first, for 31 days.

If additional premium is not required to add additional *dependents* and if *dependent* child coverage is in force as of the newborn's date of birth in the case of newborn *dependents* or the earlier of the date of adoption or placement of the child with the *employee* for purposes of adoption in case of adopted *dependents*, coverage will continue beyond the initial 31 days. *You* must notify *us* to make sure *we* have accurate records to administer benefits.

ELIGIBILITY AND EFFECTIVE DATES (continued)

If premium is required to add *dependents*, *you* must enroll the *dependent* child and pay the additional premium within 31 days:

- Of the newborn's date of birth; or
- Of the date of adoption or placement of the child with the *employee* for the purpose of adoption to add the child to *your* plan, whichever occurs first.

If enrollment is requested more than 31 days after the date of birth, date of adoption or placement with the *employee* for the purpose of adoption, and additional premium is required, the *dependent* is a *late applicant.* A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.
H217600GA 01/19

Special enrollment

Special enrollment is available if the following apply:

- *You* have a change in family status due to:

  - Marriage;
  - Divorce;
  - A Qualified Medical Child Support Order (QMCSO);
  - A National Medical Support Notice (NMSN);
  - The birth of a natural born child; or
  - The adoption of a child or placement of a child with the *employee* for the purpose of adoption; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract*, and:

  - You previously declined enrollment stating you were covered under another group health plan or other *health insurance coverage*; and
  - Loss of eligibility of such other coverage occurs, regardless of whether you are eligible for, or elect COBRA; and
  - You enroll within 31 days after the *special enrollment date*.

  Loss of eligibility of other coverage includes, but is not limited to:

  - Termination of employment or eligibility;
  - Reduction in number of hours of employment;
  - Divorce or death of a spouse;
  - Loss of dependent eligibility, such as attainment of the limiting age;
  - Termination of your employer's contribution for the coverage;
  - Loss of individual HMO coverage because you no longer reside, live or work in the service area;
  - Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available; or
  - The plan no longer offers benefits to a class of similarly situated individuals; or

ELIGIBILITY AND EFFECTIVE DATES (continued)

- You had COBRA continuation coverage under another plan at the time of eligibility, and:
  - Such coverage has since been exhausted; and
  - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
  - You enroll within 31 days after the *special enrollment date*; or
- You were covered under an alternate plan provided by the *employer* that terminates, and:
  - You are replacing coverage with the *master group contract*; and
  - You enroll within 31 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:
  - Your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
  - You enroll within 60 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:
  - You become eligible for a premium assistance subsidy under *Medicaid* or CHIP; and
  - You enroll within 60 days after the *special enrollment date*.

The *employee* or *dependent* is a *late applicant* if enrollment is requested later than the time period specified above. A *late applicant* must wait to enroll for coverage during the *open enrollment period.*
H217700GA 01/19

Dependent special enrollment

The *dependent* special enrollment is the time period specified in the "Special enrollment" provision.

If *dependent* coverage is available under the *employer's master group contract* or added to the *master group contract,* an *employee* who is a *covered person* can enroll eligible *dependents* during the special enrollment. An *employee,* who is otherwise eligible for coverage and had waived coverage under the *master group contract* when eligible, can enroll himself/herself and eligible *dependents* during the special enrollment.

The *employee* or *dependent* is a *late applicant* if enrollment is requested later than the time period specified above. A *late applicant* must wait to enroll for coverage during the *open enrollment period*.
H217800 01/19

Open enrollment

Eligible *employees* or *dependents,* who did not enroll for coverage under the *master group contract* following their *eligibility date* or *special enrollment date,* have an opportunity to enroll for coverage during the *open enrollment period*. The *open enrollment period* is also the opportunity for *late applicants* to enroll for coverage.

ELIGIBILITY AND EFFECTIVE DATES (continued)

Eligible *employees* or *dependents*, including *late applicants*, must request enrollment during the *open enrollment period*. If enrollment is requested after the *open enrollment period*, the *employee* or *dependent* must wait to enroll for coverage during the next *open enrollment period*, unless they become eligible for special enrollment as specified in the "Special enrollment" provision.
H217850 01/16

Effective date

The provisions below specify the *effective date* of coverage for *employees* or *dependents* if enrollment is requested within 31 days of their *eligibility date* or within the time period specified in the "Special Enrollment" provision. If enrollment is requested during an *open enrollment period*, the *effective date* of coverage is specified in the "Open enrollment effective date" provision.
H217890 01/19

Employee effective date

The *employee's effective date* provision is stated in the Employer Group Application. The *employee's effective date* of coverage may be the date immediately following completion of the *waiting period*, or the first of the month following completion of the *waiting period*, if enrollment is requested within 31 days of the *employee's eligibility date.* The *special enrollment date* is the *effective date* of coverage for an *employee* who requests enrollment within the time period specified in the "Special enrollment" provision. The *employee effective dates* specified in this provision apply to an *employee* who is not a *late applicant*.
H217900 01/19

Dependent effective date

The *dependent's effective date* is the date the *dependent* is eligible for coverage if enrollment is requested within 31 days of the *dependent's eligibility date.* The *special enrollment date* is the *effective date* of coverage for the *dependent* who requests enrollment within the time period specified in the "Special enrollment" provision. The *dependent effective dates* specified in this provision apply to a *dependent* who is not a *late applicant*.

In no event will the *dependent's effective date* of coverage be prior to the *employee's effective date* of coverage.
H218000 01/19

Newborn and adopted dependent effective date

The *effective date* of coverage for a newborn *dependent* is the date of birth if the newborn is not a *late applicant.*

The *effective date* of coverage for an adopted *dependent* is the date of adoption or the date of placement in the home with the *employee* for the purpose of adoption, whichever occurs first, if the *dependent* child is not a *late applicant*.

ELIGIBILITY AND EFFECTIVE DATES (continued)

Premium is due for any period of *dependent* coverage whether or not the *dependent* is subsequently enrolled, unless specifically not allowed by applicable law. Additional premium may not be required when *dependent* coverage is already in force.
H218100GA 01/19

Open enrollment effective date

The *effective date* of coverage for an *employee* or *dependent*, including a *late applicant*, who requests enrollment during an *open enrollment period*, is the first day of the *master group contract year* as agreed to by the *group plan sponsor* and *us*.
H218150 01/19

Retired employee coverage

Retired employee eligibility date

Retired *employees* are an eligible class of *employees* if requested on the Employer Group Application and if approved by *us*. An *employee*, who retires while covered under the *master group contract*, is considered eligible for retired *employee* medical coverage on the date of retirement if the eligibility requirements stated in the Employer Group Application are satisfied.
H218300 01/19

Retired employee enrollment

The *employer* must notify *us* of the *employee's* retirement within 31 days of the date of retirement. If *we* are notified more than 31 days after the date of retirement, the retired *employee* is a *late applicant*. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.
H218400 01/19

Retired employee effective date

The *effective date* of coverage for an eligible retired *employee* is the date of retirement for an *employee* who retires after the date *we* approve the *employer's* request for a retiree classification, provided *we* are notified within 31 days of the retirement. If *we* are notified more than 31 days after the date of retirement, the *effective date* of coverage for the *late applicant* is the date *we* specify.
H218500 01/19

REPLACEMENT OF COVERAGE

Applicability

This "Replacement of Coverage" section applies when an *employer's* previous group health plan not offered by *us* or *our* affiliates (Prior Plan) is terminated and replaced by coverage under the *master group contract* and:

- *You* are eligible to become covered for medical coverage on the effective date of the *master group contract*; and
- *You* were covered under the *employer's* Prior Plan on the day before the effective date of the *master group contract.*

Benefits available for *covered expense* under the *master group contract* will be reduced by any benefits payable by the Prior Plan during an extension period.
H221000 01/16

Deductible credit

Medical expense incurred while *you* were covered under the Prior Plan may be used to satisfy *your deductible* amount under the *master group contract* if the expense incurred:

- Was applied to the deductible amount under the Prior Plan; and
- Will partially or fully satisfy the *deductible* amount under the *master group contract* for the *year* in which *your* coverage becomes effective.

H221100GA 01/18

Waiting period credit

If the *employee* had not completed the initial *waiting period* under the *group plan sponsor's* Prior Plan on the day that it ended, any period of time that the *employee* satisfied will be applied to the appropriate *waiting period* under the *master group contract*, if any. The *employee* will then be eligible for coverage under the *master group contract* when the balance of the *waiting period* has been satisfied.
H221200

Out-of-pocket limit

Any amount applied to the Prior Plan's *out-of-pocket limit* or stop-loss limit will be credited toward the satisfaction of any *out-of-pocket limit* of the *master group contract* if the amount applied under the Prior Plan will partially or fully satisfy the *out-of-pocket limit* under the *master group contract* for the *year* in which *your* coverage becomes effective.
H221300 01/18

TERMINATION PROVISIONS

Termination of coverage

The date of termination, as described in this "Termination Provisions" section, may be the actual date specified or the end of that month, as selected by *your employer* on the Employer Group Application (EGA).

You and *your employer* must notify *us* as soon as possible if *you* or *your dependent* no longer meets the eligibility requirements of the *master group contract.* Notice must be provided to *us* within 31 days of the change.

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, coverage will terminate on the actual date specified by the *employer* or *employee* or at the end of that month, as selected by *your employer* on the EGA.

When *we* receive the *employer's* request to terminate coverage retroactively, the *employer's* termination request is their representation to *us* that *you* did not pay any premium to make contribution for coverage past the requested termination date.
H222000 01/17

Otherwise, coverage terminates on the earliest of the following:

- The date the *master group contract* terminates;
- The end of the period for which required premiums were paid to *us*;
- The date the *employee* terminated employment with the *employer*;
- The date the *employee* is no longer qualified as an *employee*;
- The date the *employee* no longer lives or works in the *service area*; unless *employee* agrees in writing to return to the approved *service area* for covered medical care;
- The date *you* fail to be in an eligible class of persons as stated in the EGA;
- The date the *employee* entered full-time military, naval or air service;
- The date the *employee* retired, except if the EGA provides coverage for a retiree class of *employees* and the retiree is in an eligible class of retirees, selected by the *employer*;
- The date of an *employee* request for termination of coverage for the *employee* or *dependents*;
- For a *dependent*, the date the *employee's* coverage terminates;
- For a *dependent*, the date the *employee* ceases to be in a class of *employees* eligible for *dependent* coverage;
- The date *your dependent* no longer qualifies as a *dependent*;

TERMINATION PROVISIONS (continued)

- For any benefit, the date the benefit is deleted from the *master group contract*; or

- The date fraud or intentional misrepresentation of a material fact has been committed by *you.* For more information on fraud and intentional misrepresentation, refer to the "Fraud" provision in the "Miscellaneous Provisions" section of this *certificate.*

H222100GA 01/19

Termination for cause

We will terminate *your* coverage for cause under the following circumstances:

- If *you* allow an unauthorized person to use *your* identification card or if *you* fraudulently use the identification card of another *covered person.* Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying *us* the *maximum allowable fee* for those services.

- If *you* or the *group plan sponsor* perpetrate fraud or intentional misrepresentation on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication or alteration of a claim, identification card or other identification.

H222300GA 01/16

EXTENSION OF BENEFITS

Extension of coverage for total disability

We extend limited coverage if:

- The *master group contract* terminates while *you* are *totally disabled* due to a *bodily injury* or *sickness* that occurs while the *master group contract* is in effect; and
- *Your* coverage is not replaced by the other coverage providing substantially equivalent or greater benefits than those provided for the disabling conditions by the *master group contract.*

H223000 01/18

Benefits are payable only for those expenses incurred for the same *sickness* or *bodily injury* which caused *you* to be *totally disabled.* Coverage for the disabling condition continues, but not beyond the earliest of the following dates:

- The date *your health care practitioner* certifies *you* are no longer *totally disabled*; or
- The date any maximum benefit is reached; or
- The last day of a 12 consecutive month period following the date the member terminates coverage.

H223100GA 01/16

CONTINUATION

Continuation options in the event of termination

If coverage terminates:

- It may be continued as described in the "State continuation of coverage" or the "State continuation of coverage after age 60" provision; or
- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

A complete description of the "State continuation of coverage" is below and a complete description of the "Continuation of coverage after age 60" in the Continuation after age 60 provision follows.
H224000GA 03/05

State continuation of coverage

Upon payment of premium, *you* may continue medical coverage for *you* and *your* covered *dependents* for the fraction of the *master group contract* month remaining at termination, if any, plus three additional months if:

- *You* were covered under the *master group contract* and any other group coverage providing similar benefits which the *master group contract* replaced for at least six consecutive months prior to termination;

- *Your* coverage under the *master group contract* was not terminated for any of the following reasons;

  - The *employee's* employment was terminated for cause;
  - The *employee* failed to make timely payment of premium;
  - The *group plan sponsor* terminated participation under the *master group contract* or *you* were no longer eligible for coverage under the *master group contract* with respect to an insured class; and

- Coverage is not immediately replaced by similar *group* coverage.

You must pay premium on a monthly basis in advance to the *group plan sponsor*. Premiums will be the same as those for *your* group coverage including any portion formerly paid by the *group plan sponsor*. If the *group plan sponsor's* plan terminates during the time *you* are covered under this continuation, the *group plan sponsor* must notify *you* in writing prior to the date of termination that *your* coverage is being terminated.

When coverage provided under this provision ends, *you* have the right to exercise the "State Continuation of Coverage after age 60" provision, if eligible.
H224100GA 01/16

CONTINUATION AFTER AGE 60

State continuation of coverage after age 60

This provision applies to *you* only if:

- *You* are covered under a group plan which covers 20 or more *employees*;
- *You* are 60 years of age or older on the date on which *your* coverage under COBRA or the "State continuation of coverage" provision began; and
- Coverage under COBRA or the "State continuation of coverage" provision ends.

In the event and to the extent that this provision is applicable, election of coverage under COBRA or under the "State continuation of coverage" provision shall constitute election of continuation of coverage under this provision without further action by *you*. The notice requirements of COBRA or the "State continuation of coverage" provision, whichever is applicable, shall apply to coverage provided under this provision.
H3037000

Extension of continuation

You and *your* eligible *dependents* who were covered under COBRA or the "State continuation of coverage" provision may extend *your* coverage after the expiration of the period provided under such coverage, unless the following applies to *you*;

- Termination of *your* employment was voluntary for other than health reasons;
- Termination of *your* coverage occurred because *your* employment terminated due to reasons which would cause a forfeiture of unemployment compensation under Chapter 8 of Title 34, the Employment Security Law;
- Termination of coverage was because *you* failed to pay the required premium;
- The group coverage was immediately replaced by similar group coverage; or
- The group coverage was terminated in its entirety or was terminated with respect to a class to which *you* belonged.

H3037100

Extension for survivorship continuation and extension of continuation after divorce

You and *your* covered *dependent* children, if any, whose coverage would otherwise terminate because of the dissolution of marriage or legal separation, or death of the *employee*, may continue coverage under the plan if:

- *You*, the surviving spouse, are 60 years of age or older at the time of death of the *employee*; or
- *You*, the divorced spouse, are 60 years of age or older at the time of dissolution of the marriage or legal separation.

H3037200

CONTINUATION AFTER AGE 60 (continued)

Premium

The monthly Premium for coverage under this provision will not be greater than 120% of the total of the following:

- The amount *you* would be charged, if *you* were a current group member; and
- The amount *your employer* would contribute toward the premium, if *you* were a current group member.

You must pay the first premium for coverage under this provision on the regular due date following the expiration of the period of coverage provided under COBRA or the "State continuation of coverage" provision.
H3037300

Termination of continuation

Your right to coverage under this provision will terminate on the earliest of the following:

- The date *you* fail to pay (including any grace period allowed by the policy) any required premium, when due;
- The date *your employer's* group plan is terminated, if the group plan is replaced, coverage will continue under the new group plan;
- The date *you* become insured under any group health plan; or
- The date *you* become eligible for *Medicare* coverage.

H3037400 01/16

COORDINATION OF BENEFITS

This "Coordination of Benefits" (COB) provision applies when a person has health care coverage under more than one *plan*. The order of benefit determination rules below determine which *plan* will pay as the *primary plan.* The *primary plan* pays first without regard to the possibility another *plan* may cover some expenses. A *secondary plan* pays after the *primary plan* and may reduce the benefits it pays so that payments from all *plans* do not exceed 100% of the total *allowable expense*.
H226000

Definitions

The following definitions are used exclusively in this provision.

Plan means any of the following that provide benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered part of the same *plan* and there is no COB among those separate contracts.

Plan includes:

- Group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Medical care components of long-term care contracts, such as skilled nursing care;
- Medical benefits under group or individual automobile contracts, including "No Fault" and Medical Payments coverages; and
- *Medicare* or other governmental benefits, as permitted by law. This does not include a state plan under Medicaid.

Plan does not include:

- Closed panel or other individual coverage (except for group-type coverage);
- Hospital indemnity benefits;
- School accident type coverage;
- Benefits for non-medical care components of group long-term care contracts;
- Medicare supplement policies;
- A state plan under Medicaid; and
- Coverage under other governmental plans, unless permitted by law.

Each contract for coverage is a separate *plan.* If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

COORDINATION OF BENEFITS (continued)

Notwithstanding any statement to the contrary, for the purposes of COB, prescription drug coverage under this *plan* will be considered a separate *plan* and will therefore only be coordinated with other prescription drug coverage.

Primary/secondary means the order of benefit determination stating whether this *plan* is *primary* or *secondary* covering the person when compared to another *plan* also covering the person.

When this *plan* is *primary*, its benefits are determined before those of any other *plan* and without considering any other *plan's* benefits. When this *plan* is *secondary*, its benefits are determined after those of another *plan* and may be reduced because of the *primary plan's* benefits.

Allowable expense means a health care service or expense, including deductibles, if any, and copayments, that is covered at least in part by any of the *plans* covering the person. When a *plan* provides benefits in the form of services (e.g. an HMO), the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the *plans* is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expenses*:

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is medically necessary in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for *hospital* private rooms) is not an *allowable expense*.

- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense*.

- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.

- If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*.

- The amount a benefit is reduced by the *primary plan* because a *covered person* does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of *admissions* and preferred provider arrangements.

Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this *plan*, or before the date this COB provision or a similar provision takes effect.

Closed panel plan is a *plan* that provides health benefits to covered persons primarily in the form of services through a panel of providers that has contracted with or are employed by the *plan*, and that limits or excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel member.

COORDINATION OF BENEFITS (continued)

Custodial parent means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
H226100GA 01/19

Order of determination rules

General

When two or more *plans* pay benefits, the rules for determining the order of payment are as follows:

- The *primary plan* pays or provides its benefits as if the *secondary plan* or *plans* did not exist.

- A *plan* that does not contain a COB provision that is consistent with applicable promulgated regulation is always *primary*. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the *plan* provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base *plan* hospital and surgical benefits, and insurance type coverages that are written in connection with a *closed panel plan* to provide out-of-network benefits.

- A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is *secondary* to that other *plan*.

H226200

Rules

The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.

- **Non-dependent or *dependent*.** The *plan* that covers the person other than as a *dependent*, for example as an *employee*, member, subscriber or retiree is *primary* and the *plan* that covers the person as a *dependent* is *secondary*. However, if the person is a *Medicare* beneficiary and, as a result of federal law, *Medicare* is *secondary* to the *plan* covering the person as a *dependent*; and *primary* to the *plan* covering the person as other than a *dependent* (e.g. retired *employee*); then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee*, member, subscriber or retiree is *secondary* and the other *plan* is *primary*.

- **Dependent child covered under more than one *plan*.** The order of benefits when a child is covered by more than one *plan* is:

  - The *primary plan* is the *plan* of the parent whose birthday is earlier in the year if:

    - The parents are married;
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody with out specifying that one part has the responsibility to provide health care coverage.

- If both the parents have the same birthday, the *plan* that covered either of the parents longer is *primary*.

- If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. This rule applies to *claim determination periods* or plan years commencing after the *plan* is given notice of the court decree.

- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

    - The *plan* of the *custodial parent*;
    - The *plan* of the spouse of the *custodial parent*;
    - The *plan* of the non-*custodial parent*; and then
    - The *plan* of the spouse of the non-*custodial parent.*

- **Active or inactive *employee***. The *plan* that covers a person as an *employee*, who is neither laid off nor retired, is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *employee.* If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Continuation coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an *employee*, member, subscriber or retiree (or as that person's *dependent*) is *primary*, and the continuation coverage is *secondary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Longer or shorter length of coverage**. The *plan* that covered the person as an *employee*, member, subscriber or retiree longer is *primary*.

If the preceding rules do not determine the *primary plan*, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan* under this provision. In addition, this *plan* will not pay more that it would have had it been *primary*.
H226300 01/19

Effects on the benefits of this plan

When this *plan* is *secondary*, benefits may be reduced to the difference between the allowable expense (determined by the *primary plan*) and the benefits paid by any *primary plan* during the *claim determination period*.

If a *covered person* is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and the other *closed panel plan.*
H226400 06/06

COORDINATION OF BENEFITS (continued)

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this *plan* and other *plans*. *We* may get the facts *we* need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plans* covering the person claiming benefits. *We* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give *us* any facts *we* need to apply those rules and determine benefits payable.
H226500

Facility of payment

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, *we* may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this *plan*. *We* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means a reasonable cash value of the benefits provided in the form of services.
H226600

Right of recovery

If the amount of the payments made by *us* is more than *we* should have paid under this COB provision, *we* may recover the excess from one or more of the persons *we* have paid or for whom *we* have paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person.* The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.
H226700

General coordination of benefits with Medicare

If *you* are covered under both *Medicare* and this *certificate,* federal law mandates that *Medicare* is the secondary plan in most situations. When permitted by law, this plan is the secondary plan. In all cases, coordination of benefits with *Medicare* will conform to federal statutes and regulations. If *you* are enrolled in *Medicare*, *your* benefits under this *certificate* will be coordinated to the extent benefits are payable under *Medicare,* as allowed by federal statutes and regulations.
H227100 01/19

CLAIMS

Notice of claim

Network providers will submit claims to *us* on *your* behalf. If *you* utilize a *non-network provider* for *covered expenses*, *you* must submit a notice of claim to *us*. Notice of claim must be given to *us* in writing or by *electronic mail* as required by *your* plan, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* identification documentation or at *our* Website at www.humana.com.
H228000GA 05/05

Claims must be complete. At a minimum a claim must contain:

- Name of the *covered person* who incurred the *covered expenses*;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

If *you* receive services outside the United States or from a foreign provider, *you* must also submit the following information along with *your* complete claim:

- *Your* proof of payment to the provider for the services received outside the United States or from a foreign provider;
- Complete medical information and medical records;
- *Your* proof of travel outside of the United States, such as airline tickets or passport stamps, if *you* traveled to receive the services; and
- The foreign provider's fee schedule if the provider uses a billing agency.

The forms necessary for filing proof of loss are available at www.humana.com. When requested by *you*, *we* will send *you* the forms for filing proof of loss. If the requested forms are not sent to *you* within 10 days, *you* will have met the proof of loss requirements by sending *us* a written or *electronic* statement of the nature and extent of the loss containing the above elements within the time limit stated in the "Proof of loss" provision.
H228100GA 11/12

Proof of loss

You must give written or *electronic* proof of loss within 90 days after the date *you* incur such loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof within that time period.

Your claims may be reduced or denied if written or *electronic* proof of loss is not provided to *us* within one year after the date proof of loss is required, unless *your* failure to timely provide that proof of loss is due to *your* legal incapacity as determined by an appropriate court of law.
H228200 01/19

CLAIMS (continued)

Claims processing procedures

Qualified provider services are subject to *our* claims processing procedures. *We* use *our* claims processing procedures to determine payment of *covered expenses*. *Our* claims processing procedures include, but are not limited to, claims processing edits and claim payment policies, as determined by *us*. *Your qualified provider* may access *our* code edit notifications and claim payment policies in the "Claims Resources" section at the "For Providers" link on *our* website at www.humana.com.

Claims processing procedures include the interaction of a number of factors. The amount determined to be payable for a *covered expense* may be different for each claim because the mix of factors may vary. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service;
- Whether a service is one of multiple same day services such that the cost of the service to the *qualified provider* is less than if the service had been provided on a different day. For example:
  - Two or more *surgeries* performed the same day; or
  - Two or more radiologic imaging views performed during the same session;
- Whether an *assistant surgeon*, *surgical assistant* or any other *qualified provider*, who is billing independently is involved;
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together;
- Whether the service is reasonably expected to be provided for the diagnosis reported;
- Whether a service was performed specifically for *you*; or
- Whether services can be billed as a complete set of services under one billing code.

We develop *our* claims processing procedures in *our* sole discretion based on *our* review of correct coding initiatives, national benchmarks, industry standards, and industry sources such as the following, including any successors of the same:

- *Medicare* laws, regulations, manuals and other related guidance;
- Federal and state laws, rules and regulations, including instructions published in the Federal Register;
- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual;
- American Medical Association's (AMA)/Current Procedural Terminology (CPT®) and associated AMA publications and services;
- Centers for Medicare & Medicaid Services (CMS)/Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services;
- International Classification of Diseases (ICD);
- American Hospital Association's Coding Clinic Guidelines;
- Uniform Billing Editor;
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services;
- Food and Drug Administration guidance;
- Medical and surgical specialty societies and associations;

- Industry-standard utilization management criteria and/or care guidelines;
- *Our* medical and pharmacy coverage policies; and
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed literature.

Changes to any one of the sources may or may not lead *us* to modify current or adopt new claims processing procedures.

Subject to applicable law, *qualified providers* who are *non-network providers* may bill *you* for any amount *we* do not pay even if such amount exceeds the allowed amount after *we* apply claims processing procedures. Any such amount paid by *you* will not apply to *your deductible* or any *out-of-pocket limit*. *You* will also be responsible for any applicable *deductible, copayment,* or *coinsurance*.

You or *your qualified provider* may access *our* code edit notifications, claims payment policies and *our* medical and pharmacy coverage policies at the "For Providers" link on *our* website at www.humana.com. *You* or *your qualified provider* may also call *our* toll-free customer service number listed on *your* ID card to obtain a copy of a code edit notification, claims payment policy or coverage policy. *You* should discuss these code edit notifications, claims payment policies and coverage policies and their availability with any *qualified provider* prior to receiving any services.
H228250 01/19

Right to require medical examinations

We have the right to require a medical examination on any *covered person* as often as *we* may reasonably require. If *we* require a medical examination, it will be performed at *our* expense. *We* also have a right to request an autopsy in the case of death, if state law so allows.
H228300

To whom benefits are payable

If *you* receive services from a *network provider*, *we* will pay the provider directly for all *covered expenses*. *You* will not have to submit a claim for payment.

All benefit payments for *covered expenses* rendered by a *non-network provider*. However, with *our* consent, a *covered person* may direct *us* to pay all or any part of the medical benefits to the health care provider on whose charge the claim is based. If *we* pay *you* directly, *you* are then responsible for any and all payments to the *non-network provider*(s).

If any *covered person* to whom benefits are payable is a minor or, in *our* opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her parent or legal guardian. However, if no request for payment has been made by the parent or legal guardian, *we* may, at *our* option, make payment to the person or institution appearing to have assumed his or her custody and support.
H228400GA 01/16

CLAIMS (continued)

Time of payment of claims

Payments due under the *master group contract* will be paid no more than 30 days after receipt of written or 15 working days for *electronic* proof of loss.

If *we* fail to provide benefits payable under the *master group contract* upon receipt of written or *electronic* proof of loss, *we* shall have 15 working days thereafter to send *you* a letter or notice which:

- States the reason(s) *we* have not paid the claim; and
- Gives a written itemization of any documents or other information needed to process the claim.

When all of the listed documents or other information needed to process the claim has been received, *we* shall have 15 working days thereafter to either pay or deny the claim and give *you* the reasons if there is a denial.

Claims not paid as above will be increased by interest at 12% per annum on the proceeds or benefits due under the terms of the *master group contract.*
H228500GA 02/12

Right to request overpayments

We reserve the right to recover any payments made by *us* that were:

- Made in error;
- Made to *you* or any party on *your* behalf, where *we* determine such payment made is greater than the amount payable under the *master group contract*;
- Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
- Made to *you* and/or any party on *your* behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to the *deductible, out-of-pocket limit* or *copayment limit,* if any.
H228700 01/16

Right to collect needed information

You must cooperate with *us* and when asked, assist *us* by:

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information or records from any provider as requested by *us*;
- Providing information regarding the circumstances of *your sickness*, *bodily injury* or *accident*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits;

CLAIMS (continued)

- Providing copies of claims and settlement demands submitted to third parties in relation to a *bodily injury* or *sickness*;
- Disclosing details of liability settlement agreements reached with third parties in relation to a *bodily injury* or *sickness*; and
- Providing information *we* request to administer the *master group contract.*

If *you* fail to cooperate or provide the necessary information, *we* may recover payments made by *us* and deny any pending or subsequent claims for which the information is requested.
H228800 01/16

Exhaustion of time limits

If *we* fail to complete a claim determination or appeal within the time limits set forth in the *master group contract,* the claim shall be deemed to have been denied and *you* may proceed to the next level in the review process outlined under the "Grievance Procedures" section of this *certificate* or as required by law.
H228900GA 02/06

Duty to cooperate in good faith

You are obligated to cooperate with *us* and *our* agents in order to protect *our* recovery rights. Cooperation includes promptly notifying *us you* may have a claim, providing *us* relevant information, and signing and delivering such documents as *we* or *our* agents reasonably request to secure *our* recovery rights. *You* agree to obtain *our* consent before releasing any party from liability for payment of medical expenses. *You* agree to provide *us* with a copy of any summons, complaint or any other process served in any lawsuit in which *you* seek to recover compensation for *your* injury and its treatment.

You will do whatever is necessary to enable *us* to enforce *our* recovery rights and will do nothing after loss to prejudice *our* recovery rights.

You agree that *you* will not attempt to avoid *our* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

In the event that *you* fail to cooperate with *us, we* shall be entitled to recover from *you* any payments made by *us.*
H229100 01/16

Workers' compensation

This *master group contract* excludes coverage for *sickness* or *bodily injury* for which Workers' Compensation or similar coverage is available.

If benefits are paid by *us* and *we* determine that the benefits were for treatment of *bodily injury* or *sickness* that arose from or was sustained in the course of, any occupation or employment for compensation, profit or gain, *we* have the right to recover as described below.

CLAIMS (continued)

We shall have first priority to recover amounts *we* have paid and the reasonable value of services and benefits provided under a managed care agreement from any funds that are paid or payable by Workers' Compensation or similar coverage as a result of any *sickness* or *bodily injury*, and *we* shall not be required to contribute to attorney fees or recovery expenses under a Common Fund or similar doctrine.

Our right to recover from funds that are paid or payable by Workers' Compensation or similar coverage will apply even though:

- The Workers' Compensation carrier does not accept responsibility to provide benefits;
- There is no final determination that *bodily injury* or *sickness* was sustained in the course of or resulted from *your* employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier, or
- Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

As a condition to receiving benefits from *us*, *you* hereby agree, in consideration for the coverage provided by the *master group contract, you* will notify *us* of any Workers' Compensation claim *you* make, and *you* agree to reimburse *us* as described above. If *we* are precluded from exercising *our* recovery rights to recover from funds that are paid by Workers' Compensation or similar coverage *we* will exercise *our* right to recover against *you.*
H229300 01/16

Right of reimbursement; coverage voided by non-cooperation

If *you* or *your* covered *dependent* has a claim for damages or a right to recover damages from a legally responsible person, their insurer, or any uninsured motorist or underinsured motorist, or other similar coverage for any *sickness* or *bodily injury* for which benefits are payable under this *master group contract*. *We* may have the "Right of Reimbursement." "Our Right of Reimbursement" shall be limited to the recovery of any benefits paid for medical expenses, prescription and specialty drugs, disability, or dental under this *policy*, but shall not include non-medical items. Recovery may include compromise, judgment, or other settlements. Should a dispute as to the amount of reimbursement arise, the health plan may seek a declaratory judgment in court as to what amount is due, if any. "Our Right to Reimbursement" is limited by any applicable state law or rule limiting the rights of the insurer to recover the expenses it has paid on *your* behalf. The beneficiary will cooperate with *us* in an effort to recover from the legally liable person or insured for *bodily injuries* and losses, which necessitate *covered expenses* by this *master group contract. You* or *your* attorney must inform *us* of any legal action or settlement agreement at least ten days prior to settlement or trial. *We* will then notify *you* of the amount *we* seek to recover for covered benefits paid. *Our* recovery may be reduced by the pro-rata share of *your* attorney's fees and expenses of litigation.
H229350GA 01/19

GRIEVANCE PROCEDURES

There are situations when *covered persons* are dissatisfied with the *group plan's* services. Such grievances will be handled on a timely basis and appropriate records will be kept on all complaints.

The person responsible for the maintenance of records and for the supervision of the grievance process is the Executive Director/Designee. A specific set of records will be maintained to document grievances filed. Records will include reason for grievance, date filed, consequent actions and final disposition. They will be centrally maintained by the Grievance Manager.

We will encourage *covered persons* to resolve individual problems without initiation of a formal grievance by contacting the Customer Service Representative for verbal resolution. Refer to *your* ID card for the Customer Service phone number. Grievances must be submitted within 30 days of occurrence, unless good cause can be shown. The Customer Service Representative must respond to the complaint within three working days of the submission.

In the event the grievance has not been settled at the informal level and the *covered person* is still dissatisfied, the *covered person* will be advised to appeal the decision in writing to the Grievance Manager. In the case of a medical or quality of care grievance, the investigation will include referral to a Physician Advisor for consultation, but the process will remain the same. The Grievance Manager will provide written acknowledgment of receipt of the grievance to the *covered person* within five working days; the grievance will be investigated and a response sent to the *covered person* no later than 30 working days following the initial filing of the appeal with the Grievance Manager. The *covered person* or any interested party may submit written data which will remain part of the file.

If the *covered person* is not satisfied with the response, the *covered person* may appeal directly to the Grievance Committee. The *covered person* will be advised in writing of the right to appeal the decision. The Grievance Committee shall have written guidelines for investigating grievances and conducting hearings. As before, receipt of the grievance will be acknowledged within five working days by the Grievance Committee.

In the event a hearing is held, such hearing shall be conducted by a panel of at least three persons. One member of the panel must be a physician other than *our* Medical Director, and one must be a *health care practitioner* competent by reason of training and licensure in the treatment or procedure that has been denied. The Grievance Committee's suggested resolution will be sent to the *covered person* within 30 working days.

If the *covered person* remains dissatisfied with the decision of the Grievance Committee, the *covered person* will be advised of the right to appeal to the Commissioner of Insurance at:

Department of Insurance
Consumer Services/Complaints Section
Martin Luther King, Jr. Drive
7th Floor, West Tower, No. 2
Atlanta, Georgia 30334

GRIEVANCE PROCEDURES (continued)

A *covered person* may also write to:

Georgia Department of Human Resources
Office of Regulatory Services
2 Peachtree Street, NW Suite 19-204
Atlanta, Georgia 30303-3142

Once *we* receive a copy of the complaint from the department, *we* will provide a written response to the complainant within ten working days. Copies of *our* response will be sent to the Department of Insurance and the Department of Human Resources.

The grievance process does not preclude *you* from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for grievance and review places *your* health in serious jeopardy.
H230000GA

Exhaustion of remedies

You must complete all levels of the grievance process available to *you* under state or federal law before filing a law suit. This assures that both *you* and *we* have a full and fair opportunity to complete the record and resolve the dispute. Contact *us* if *you* believe *your* condition requires the use of the shorter time lines applicable to emergency health conditions.

The grievance process, however, does not stop *you* from pursuing other appropriate remedies, including seeking injunctive relief or equitable relief, if the requirement of exhausting the process for grievances, including the emergency grievance process, would place *your* health in serious jeopardy.

A coverage denial does not mean that *your* provider cannot provide the service or supply. *Our* denial only means *we* will not pay for the service or supply, unless *our* decision is reversed on appeal or in a subsequent lawsuit.
H230100GA 01/19

Legal actions and limitations

No legal action to recover on the *master group contract* may be brought until 60 days after written proof of loss has been given in accordance with the "Proof of loss" provision of the *master group contract.*

No legal action to recover on the *master group contract* may be brought after three years from the date written proof of loss is required to be given.
H230200GA 01/19

DISCLOSURE PROVISIONS

Employee assistance program

We may provide *you* access to an employee assistance program (EAP). The EAP may include confidential, telephonic consultations and work-life services. The EAP provides *you* with short-term, problem solving services for issues that may otherwise affect *your* work, personal life or health. The EAP is designed to provide *you* with information and assistance regarding *your* issue and may also assist *you* with finding a medical provider or local community resource.

The services provided by the EAP are not *covered expenses* under the *master group contract*, therefore the *copayments*, *deductible* or *coinsurance* do not apply. However, there may be additional costs to *you*, if *you* obtain services from a professional or organization the EAP has recommended or has referred *you* to. The EAP does not provide medical care. *You* are not required to participate in the EAP before using *your* benefits under the *master group contract*, and the EAP services are not coordinated with *covered expenses* under the *master group contract*. The decision to participate in the EAP is voluntary, and *you* may participate at any time during the *year*. Refer to the marketing literature for additional information.
H230500GA 01/16

Discount programs

From time to time, *we* may offer or provide access to discount programs to *you*. In addition, *we* may arrange for third party service providers such as pharmacies, optometrists, dentists and alternative medicine providers to provide discounts on goods and services to *you*. Some of these third party service providers may make payments to *us* when *covered persons* take advantage of these discount programs. These payments offset the cost to *us* of making these programs available and may help reduce the costs of *your* plan administration. Although *we* have arranged for third parties to offer discounts on these goods and services, these discount programs are not covered services under the *master group contract*. The third party service providers are solely responsible to *you* for the provision of any such goods and/or services. *We* are not responsible for any such goods and/or services, nor are *we* liable if vendors refuse to honor such discounts. Further, *we* are not liable to *covered persons* for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.
H230985 01/17

Wellness programs

From time to time *we* may offer directly, or enter into agreements with third parties who administer participatory or health-contingent wellness programs to *you*.

"Participatory" wellness programs do not require *you* to meet a standard related to a health factor. Examples of participatory wellness programs may include, but are not limited to, membership in a fitness center, certain preventive testing, or attending a no-cost health education seminar.

DISCLOSURE PROVISIONS (continued)

"Health-contingent" wellness programs require you to attain certain wellness goals that are related to a health factor. Examples of health contingent wellness programs may include, but are not limited to, completing a 5k event, lowering blood pressure or ceasing the use of tobacco.

The rewards may include, but are not limited to, payment for all or a portion of a participatory wellness program, merchandise, gift cards, debit cards, discounts or contributions to *your* health spending account. *We* are not responsible for any rewards provided by third parties that are non-insurance benefits or for *your* receipt of such reward(s).

The rewards may also include, but are not limited to, discounts or credits toward premium or a reduction in *copayments*, *deductibles* or *coinsurance*, as permitted under applicable state and federal laws. Such insurance premium or benefit rewards may be made available at the individual or *group* health plan level.

The rewards may be taxable income. *You* may consult a tax advisor for further guidance.

Our agreement with any third party does not eliminate any of *your* obligations under this *master group contract* or change any of the terms of this *master group contract.* Our agreement with the third parties and the program may be terminated at any time, although insurance benefits will be subject to applicable state and federal laws.

We are committed to helping *you* achieve *your* best health. Some wellness programs may be offered only to *covered persons* with particular health factors. If *you* think *you* might be unable to meet a standard for a reward under a wellness program, *you* might qualify for an opportunity to earn the same reward by different means. Contact *us* at the number listed on *your* ID card or in the marketing literature issued by the wellness program administrator for more information.

The wellness program administrator or *we* may require proof in writing from *your health care practitioner* that *your* medical condition prevents *you* from taking part in the available activities.

The decision to participate in wellness program activities is voluntary and if eligible, *you* may decide to participate anytime during the *year*. Refer to the marketing literature issued by the wellness program administrator for their program's eligibility, rules and limitations.
H231075 01/16

Shared savings program

As a *covered person* under the health benefit plan, coverage is limited to *network providers*, unless for *emergency care.* For coverage to be available for *non-network providers* other than *emergency care*, *you* must receive a referral from *us.*

DISCLOSURE PROVISIONS (continued)

If *you* choose to obtain services from a *non-network provider*, the services may be eligible for a discount to *you* under the Shared Savings Program. It is not necessary for *you* to inquire in advance about services that may be discounted. When processing *your* claim, *we* will automatically determine the services are subject to the Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. Whether services are subject to the Shared Savings Program is at our discretion, and *we* apply the discounts in a non-discriminatory manner. *Your* Explanation of Benefits statement will reflect any savings with a remark code that the services have been discounted. *We* cannot guarantee that services rendered by *non-network providers* will be discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

If *you* would like to inquire in advance to determine if services rendered by a *non-network provider* may be subject to the Shared Savings Program, please contact *our* customer service department at the telephone number shown on *your* ID card. Provider arrangements in the Shared Savings Program are subject to change without notice. *We* cannot guarantee that the services you receive from a *non-network provider* are still subject to the Shared Savings Program at the time services are received. Discounts are dependent upon availability and cannot be guaranteed.

We reserve the right to modify, amend or discontinue the Shared Savings Program at any time.
H231100 01/18

MISCELLANEOUS PROVISIONS

Entire contract

The entire contract is made up of the *master group contract*, the *certificate*, the Employer Group Application of the *group plan sponsor*, incorporated by reference herein, and the applications or enrollment forms, if any, of the *covered persons.* All statements made by the *group plan sponsor* or by a *covered person* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement will void the *master group contract*, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or *electronic* application or enrollment form and a copy is furnished to the person making such statement or his or her beneficiary.
H232000GA 01/19

Additional group plan sponsor responsibilities

In addition to responsibilities outlined in the *master group contract,* the *group plan sponsor* is responsible for:

- Collection of premium; and
- Distributing and providing *covered persons* access to:

  - Benefit plan documents and the Summary of Benefits and Coverage (SBC);
  - Renewal notices and *master group contract* modification information;
  - Discontinuance notices; and
  - Information regarding continuation rights.

No *group plan sponsor* may change or waive any provision of the *master group contract.*
H232100 01/18

Certificates

A printed *certificate* will be furnished to the *employer*. The *employer* shall deliver an individual certificate to each *employee.* Additionally, the *certificate* will be available to the *employer* and *employee* at www.humana.com or in writing when requested.
H232200GA 11/12

No document inconsistent with the *master group contract* shall take precedence over it. This is true, also, when the *certificate* is incorporated by reference into a summary description of plan benefits by the administrator of a group plan subject to ERISA. If the terms of a summary plan description differ with the terms of this *certificate* respecting coverage, the terms of this *certificate* will control.
H232300 01/18

MISCELLANEOUS PROVISIONS (continued)

Incontestability

No misstatement made by the *group plan sponsor*, except for fraud or an intentional misrepresentation of a material fact made in the application may be used to void the *master group contract.*

After *you* are covered without interruption for two years, *we* cannot contest the validity of *your* coverage, except for:

- Nonpayment of premiums; or
- Any fraud or intentional misrepresentation of a material fact made by *you.*

At any time, *we* may assert defenses based upon provisions in the *master group contract* which relate to *your* eligibility for coverage under the *master group contract.*

No statement made by *you* can be contested unless it is in a written or *electronic* form signed by *you.* A copy of the form must be given to *you* or *your* beneficiary.

An independent incontestability period begins for each type of change in coverage or when a new application or enrollment form of the *covered person* is completed.
H232400 11/12

Fraud

Health insurance fraud is a criminal offense that can be prosecuted. Any person(s) who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains a false or deceptive statement may be guilty of insurance fraud.

If *you* commit fraud against *us* or with *your* consent *your employer* knowingly submits incorrect or misleading information in the application pertaining to *you* against *us,* as determined by *us, we* reserve the right to *rescind your* coverage after *we* provide *you* a 30 calendar day advance written notice that coverage will be *rescinded*. *You* have the right to appeal the *rescission.*
H232500GA 11/12

Clerical error or misstatement

If it is determined that information about a *covered person* was omitted or misstated in error, an adjustment may be made in premiums and/or coverage in effect. This provision applies to *you* and to *us.*
H232600 11/12

Modification of master group contract

The *master group contract* may be modified by *us,* upon renewal of the *master group contract,* as permitted by state and federal law. The *group plan sponsor* will be notified in writing or *electronically* as follows:

MISCELLANEOUS PROVISIONS (continued)

- For a *small employer*, at least 60 days prior to the effective date of the change;
- For a large *employer*, at least 31 days prior to the effective date of the change.

The *master group contract* may be modified by agreement between *us* and the *group plan sponsor* without the consent of any *covered person* or any beneficiary. No modification will be valid unless approved by *our* President, Secretary or Vice-President. The approval must be endorsed on or attached to the *master group contract.* No agent has authority to modify the *master group contract*, or waive any of the *master group contract* provisions, to extend the time of premium payment, or bind *us* by making any promise or representation.

Corrections due to clerical errors or clarifications that do not change benefits are not modifications of the *master group contract* and may be made by *us* at any time without prior consent of, or notice to, the *group plan sponsor*.
H232700GA 01/17

Discontinuation of coverage

If *we* decide to discontinue offering a particular group health plan:

- The *group plan sponsor* and the *employees* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
- The *group plan sponsor* will be given the option to purchase all (or, in the case of a large *employer*, any) other group plans providing medical benefits that are being offered by *us* at such time.

If *we* cease doing business in the *small employer* or the large *employer* group market, the *group plan sponsors*, *covered persons* and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.
H232750 01/19

Premium contributions

Your employer must pay the required premium to *us* as they become due. *Your employer* may require *you* to contribute toward the cost of *your* coverage. Failure of *your employer* to pay any required premium to *us* when due may result in the termination of *your* coverage. If the required premium is not paid by the end of the 31 day grace period, this *master group* contract will terminate.

If the *covered person* is *totally disabled* when coverage terminates, *we* will extend limited coverage as described in "Extension of Benefits."
H232800GA 01/19

MISCELLANEOUS PROVISIONS (continued)

Premium rate change

We reserve the right to change any premium rates, provided the change in rates will not apply to existing master group sponsor, who has not been effective under this *master group contract* for 12 consecutive months, in accordance with applicable law upon notice to the *employer*. *We* will provide notice to the *employer* of any such premium changes at least 60 days prior to the effective date of the premium increase. Questions regarding changes to premium rates should be addressed to the *employer*.
H232900GA 03/05

Small employers' rate disclosure

You may request information on how *we* determine premium rates by calling the Customer Service telephone number found on the back of *your* member identification card.
H232950GA 02/06

Assignment

The *master group contract* and its benefits may not be assigned by the *group plan sponsor*.
H233100

Conformity with statutes

Any provision of the *master group contract* which is not in conformity with applicable state law(s) or other applicable law(s) shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable state law(s) and other applicable law(s).
H233200

GLOSSARY

Terms printed in italic type in this *certificate* have the meaning indicated below. Defined terms are printed in italic type wherever found in this *certificate.*
H234000

A

Accident means a sudden event that results in a *bodily injury* or *dental injury* and is exact as to time and place of occurrence.

Active status means the *employee* is performing all of his or her customary duties, whether performed at the *employer's* business establishment, some other location which is usual for the *employee's* particular duties or another location, when required to travel on the job:

- On a regular *full-time* basis or for the number of hours per week determined by the *group plan sponsor*;
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship with the *group plan sponsor* of the *master group contract* on a regular basis.

Each day of a regular vacation and any regular non-working holiday are deemed *active status*, if the *employee* was in *active status* on his or her last regular working day prior to the vacation or holiday. An *employee* is deemed to be in *active status* if an absence from work is due to a *sickness* or *bodily injury*, provided the individual otherwise meets the definition of *employee*.

Acute inpatient services mean care given in a *hospital* or *health care treatment facility* which:

- Maintains permanent full-time facilities for *room and board* of resident patients;
- Provides emergency, diagnostic and therapeutic services with a capability to provide life-saving medical and psychiatric interventions;
- Has physician services, appropriately licensed behavioral health practitioners and skilled nursing services available 24-hours a day;
- Provides direct daily involvement of the physician; and
- Is licensed and legally operated in the jurisdiction where located.

Acute inpatient services are utilized when there is an immediate risk to engage in actions which would result in death or harm to self or others or there is a deteriorating condition in which an alternative treatment setting is not appropriate.

Admission means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An *admission* ends when *you* are discharged, or released, from the facility and are no longer registered as a bed patient.

Advanced imaging, for the purpose of this definition, includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT), and Computed Tomography (CT) imaging.

GLOSSARY (continued)

Alternative medicine, for the purposes of this definition, includes, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal supplements and medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu, yoga and chelation therapy.

Ambulance means a professionally operated vehicle, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury.* Use of the *ambulance* must be *medically necessary* and/or ordered by a *health care practitioner*.

Ambulatory surgical center means an institution which meets all of the following requirements:

- It must be staffed by physicians and a medical staff which includes registered nurses.
- It must have permanent facilities and equipment for the primary purpose of performing *surgery.*
- It must provide continuous physicians' services on an *outpatient* basis.
- It must admit and discharge patients from the facility within a 24-hour period.
- It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an *ambulatory surgical center* as defined by those laws.
- It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

Assistant surgeon means a *health care practitioner* who assists at *surgery* and is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM) or where state law requires a specific *health care practitioner* be treated and reimbursed the same as an MD, DO or DPM.
H234800 01/19

B

Behavioral health means *mental health services* and *chemical dependency* services.

Bodily injury means bodily damage other than a *sickness*, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

Bone marrow means the transplant of human blood precursor cells. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. The term *bone marrow* includes the harvesting, the transplantation and the integral chemotherapy components.
H235100 01/16

C

Cancer screenings and examinations means screenings and examinations for cancer in accordance with the most recently published guidelines and recommendations established by any of the following:

GLOSSARY (continued)

- American College of Physicians;
- American College of Obstetricians and Gynecologists; or
- American Academy of Pediatricians.

Certificate means this benefit plan document that describes the benefits, provisions and limitations of the *master group contract.* The *certificate* is part of the *master group contract* and is subject to the terms of the *master group contract.*

Chemical dependency means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay.

Confinement or ***confined*** means *you* are a registered bed patient as the result of a *health care practitioner's* recommendation. It does not mean *you* are in *observation status*.

Congenital anomaly means an abnormality of the body that is present from the time of birth.

Copayment means the specified dollar amount *you* must pay to a provider for *covered expenses*, regardless of any amounts that may be paid by *us*.

Cosmetic surgery means *surgery* performed to reshape normal structures of the body in order to improve or change *your* appearance or self-esteem.

Covered expense means:

- *Medically necessary* services to treat a *sickness* or *bodily injury*, such as:
  - Procedures;
  - *Surgeries*;
  - Consultations;
  - Advice;
  - Diagnosis;
  - Referrals;
  - Treatment;
  - Supplies;
  - Drugs, including *prescription* and *specialty drugs*;
  - Devices; or
  - Technologies;
- *Preventive services.*

To be considered a *covered expense*, services must be:

- Ordered by a *health care practitioner*;
- Authorized or prescribed by a *qualified provider*;
- Provided or furnished by a *qualified provider*;
- For the benefits described herein, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *master group contract*; and

GLOSSARY (continued)

- Incurred when *you* are insured for that benefit under the *master group contract* on the date that the service is rendered.

Covered person means the *employee* or the *employee's dependents*, who are enrolled for benefits provided under the *master group contract.*

Custodial care means services given to *you* if:

- *You* need services including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, maintaining continence;
- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or
- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

Services may still be considered *custodial care* by *us* even if:

- *You* are under the care of a *health care practitioner*;
- The *health care practitioner* prescribed services are to support or maintain *your* condition; or
- Services are being provided by a *nurse*.

H236100GA 01/19

D

Deductible means the amount of *covered expenses* that *you*, either individually or combined as a covered family, must pay per *year* before *we* pay benefits for certain specified *covered expenses*.

Dental injury means an injury to a *sound natural tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries, unless the biting or chewing injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

Dependent means a covered *employee's*:

- Legally recognized spouse;
- Natural born child, step-child, legally adopted child, or child placed for adoption, whose age is less than the limiting age;
- Grandchild or great grandchild if a written power of attorney exists that gives a grandparent authority to act on behalf of the grandchild. A parent of a minor child may delegate to any grandparent residing in this state, caregiving authority regarding the minor child when hardship prevents the parent from caring for the child.

GLOSSARY (continued)

- Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:
  - Such QMCSO or NMSN is no longer in effect; or
  - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *master group contract.*

Under no circumstances shall *dependent* mean a grandchild, great grandchild or foster child, including where the grandchild, great grandchild, or foster child meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The limiting age means the end of the month the *dependent* child attains age 26. Each *dependent* child is covered to the limiting age, regardless if the child is:

- Married;
- A tax dependent;
- A student;
- Employed;
- Residing with or receiving financial support from *you*;
- Eligible for other coverage through employment; or
- Residing or working outside of the *service area*. Benefits for *dependents* residing outside of the *service area* are limited to *emergency care* and *urgent care* services as specified in the "Dependent eligibility date" provision, unless additional coverage is provided by addenda or authorized by *us*.

A covered *dependent* child who attains the limiting age while covered under the *master group contract* remains eligible if the covered *dependent* child is:

- Permanently mentally or physically handicapped;
- Incapable of self-sustaining employment; and
- Unmarried.

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days prior to the covered *dependent* child attaining the limiting age.

You must furnish satisfactory proof to *us*, upon *our* request, that the conditions, as defined in the bulleted items above, continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, *we* may not request such proof more often than annually. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

GLOSSARY (continued)

Diabetes equipment means blood glucose monitors and glucose monitors, including monitors designed to be used by legally blind or visually impaired individuals; injection aids, including those adaptable to meet the needs of the legally blind; insulin pumps and associated accessories; insulin infusion devices; and podiatric appliances and therapeutic shoes for the prevention of complications associated with diabetes; pen-like insulin injection devices; lancing devices associated with the drawing of blood samples for use with blood glucose monitors; and other medical equipment non-disposable and durable medical equipment consistent with the current standards of care of the American Diabetes Association.

Diabetes self-management training means the training provided to a *covered person* after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of *diabetes equipment* and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

Diabetes supplies means test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes, including insulin syringes, insulin injection needles for use with pen-like insulin injection devices and other disposable parts required for insulin injection aids; prescriptive agents for controlling blood sugar levels; prescriptive non-insulin injectable agents for controlling blood sugar levels; glucagon emergency kits; and alcohol swabs and other single-use medical supplies consistent with the current standards of care of the American Diabetes Association.

Distant site means the location of a *health care practitioner* at the time a *telehealth* or *telemedicine* service is provided.

Durable medical equipment means equipment that meets all of the following criteria:

- It is prescribed by a *health care practitioner*;
- It can withstand repeated use;
- It is primarily and customarily used for a medical purpose rather than being primarily for comfort or convenience;
- It is generally not useful to *you* in the absence of *sickness* or *bodily injury*;
- It is appropriate for home use or use at other locations as necessary for daily living;
- It is related to and meets the basic functional needs of *your* physical disorder;
- It is <u>not</u> typically furnished by a *hospital* or *skilled nursing facility*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

H236800GA 01/19

E

Effective date means the date *your* coverage begins under the *master group contract.*

Electronic or Electronically means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

Electronic mail means a computerized system that allows a user of a network computer system and/or computer system to send and receive messages and documents among other users on the network and/or with a computer system.

GLOSSARY (continued)

Electronic signature means an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

Eligibility date means the date the *employee* or *dependent* is eligible to participate in the plan.

Emergency care means services provided in a *hospital* emergency facility for a *bodily injury* or *sickness* manifesting itself by acute symptoms of recent or sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could not judge the severity of the condition and reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency care does not mean services for the convenience of the *covered person* or the provider of treatment or services.

Employee means a person who is in *active status* for the *employer* on a *full-time* basis. The *employee* must be paid a salary or wage by the *employer* that meets the minimum wage requirements of *your* state or federal minimum wage law for work done at the *employer's* usual place of business or some other location, which is usual for the *employee's* particular duties.

Employee also includes a sole proprietor, partner or corporate officer where:

- The *employer* is a sole proprietorship, partnership or corporation;
- The sole proprietorship or other entity (other than a partnership) has at least one common-law employee (other than the business owner and his or her spouse); and
- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, gains their livelihood from the sole proprietorship, partnership or corporation and is in an *active status* at the *employer's* usual place of business or some other location which is usual for the sole proprietor's, partner's or corporate officer's particular duties.

If specified on the Employer Group Application and approved by *us*, *employee* also includes retirees of the *employer*. A retired *employee* is not required to be in *active status* to be eligible for coverage under the *master group contract.*

Employer means the sponsor of this *group* plan, or any subsidiary or affiliate described in the Employer Group Application. An *employer* must either employ at least one common-law employee or be a partnership with a bona fide partner who provides services on behalf of the partnership. A business owner and his or her spouse are not considered common-law employees for this purpose if the entity is considered to be wholly owned by one individual or one individual and his or her spouse.

GLOSSARY (continued)

Endodontic services mean the following dental procedures, related tests or treatment and follow-up care:

- Root canal therapy and root canal fillings;
- Periradicular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

Essential health benefits mean the following categories, as defined by the United States Health and Human Services (HHS) as set forth by the Affordable Care Act, and federal regulations:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorders, including *behavioral health* treatment;
- *Prescription* drugs;
- Rehabilitative and *habilitative services* and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Experimental, ***investigational*** or ***for research purposes*** means a drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by *us*:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information, (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;

- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;

- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or

- Is identified as not covered by the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

H238000GA 01/19

GLOSSARY (continued)

F

Family member means *you* or *your* spouse. It also means *your* or *your* spouse's child, brother, sister, or parent.

Free-standing facility means any licensed public or private establishment other than a *hospital* which has permanent facilities equipped and operated to provide laboratory and diagnostic laboratory, *outpatient* radiology, *advanced imaging*, chemotherapy, inhalation therapy, radiation therapy, lithotripsy, physical, cardiac, speech and occupational therapy, or renal dialysis services. An appropriately licensed birthing center is also considered a *free-standing facility*.

Full-time, for an *employee*, means a work week of the number of hours determined by the *group plan sponsor*.

Functional impairment means a direct and measurable reduction in physical performance of an organ or body part.
H238300 01/19

G

Group means the persons for whom this health coverage has been arranged to be provided.

Group plan sponsor means the legal entity identified as the *group plan sponsor* on the face page of the *master group contract* or "Certificate of Coverage" who establishes, sponsors and endorses an employee benefit plan for health care coverage.
H238450 11/12

H

Habilitative services mean health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health care practitioner means a practitioner professionally licensed by the appropriate state agency to provide *preventive services* or diagnose or treat a *sickness* or *bodily injury* and who provides services within the scope of that license.

Health care treatment facility means a facility, institution or clinic, duly licensed by the appropriate state agency to provide medical services, *behavioral health* services, and is primarily established and operating within the scope of its license.

GLOSSARY (continued)

Health insurance coverage means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization (HMO) contract offered by a health insurance issuer. "Health insurance issuer" means an insurance company, insurance service or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to the state law that regulates insurance.

Health status-related factor means any of the following:

- Health status or medical history;
- Medical condition, either physical or mental;
- Claims experience;
- Receipt of health care;
- Genetic information;
- Disability; or
- Evidence of insurability, including conditions arising out of acts of domestic violence.

Hearing aid means any nonexperimental and wearable instrument or device offered to aid or compensate for impaired hearing that is worn in or on the body. The term *hearing aid* includes any parts, ear molds, repair parts, and replacement parts of such instrument or device, including, but not limited to, non-implanted bone anchored *hearing aids*, non-implanted bone conduction *hearing aids*, and frequency modulation systems. Personal sound amplification products do not qualify as *hearing aids*.

Home health care agency means a *home health care agency* or *hospital* which meets all of the following requirements:

- It must primarily provide skilled nursing services and other therapeutic services under the supervision of physicians or registered nurses;
- It must be operated according to established processes and procedures by a group of medical professionals, including *health care practitioners* and *nurses*;
- It must maintain clinical records on all patients; and
- It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction which pertains to agencies providing home health care.

Home health care plan means a plan of care and treatment for *you* to be provided in *your* home. To qualify, the *home health care plan* must be established and approved by a *health care practitioner*. The services to be provided by the plan must require the skills of a *nurse*, or another *health care practitioner* and must not be for *custodial care*.

Hospice care program means a coordinated, interdisciplinary program provided by a hospice that is designed to meet the special physical, psychological, spiritual and social needs of a terminally ill *covered person* and his or her immediate covered *family members*, by providing *palliative care* and supportive medical, nursing and other services through at-home or *inpatient* care. A hospice must be licensed by the laws of the jurisdiction where it is located and must be operated as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* and, as estimated by their physicians, are expected to live 18 months or less as a result of that *sickness*.

GLOSSARY (continued)

Hospital means an institution that meets all of the following requirements:

- It must provide, for a fee, medical care and treatment of sick or injured patients on an *inpatient* basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic and surgical facilities;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a *hospital* as defined by those laws; and
- It must not be primarily a:
  - Convalescent, rest or nursing home; or
  - Facility providing custodial, educational or rehabilitative care.

The *hospital* must be accredited by one of the following:

- The Joint Commission on the Accreditation of Hospitals;
- The American Osteopathic Hospital Association; or
- The Commission on the Accreditation of Rehabilitative Facilities.

H239200GA 01/19

I

Infertility services mean any treatment, supply, medication, or service provided to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking; and
- Any other assisted reproductive techniques or cloning methods.

Inpatient means *you* are *confined* as a registered bed patient.

Intensive outpatient program means *outpatient* services providing:

- Group therapeutic sessions greater than one hour a day, three days a week;
- *Behavioral health* therapeutic focus;
- Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;

GLOSSARY (continued)

- Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *chemical dependency*; and
- Physician availability for medical and medication management.

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

H239600 01/19

J

K

L

Late applicant means an *employee* or *dependent* who requests enrollment for coverage under the *master group contract* more than 31 days after his or her *eligibility date*, later than the time period specified in the "Special enrollment" provision, or after the *open enrollment period*.
H239700 01/19

M

Maintenance care means services and supplies furnished mainly to:

- Maintain, rather than improve, a level of physical or mental function; or
- Provide a protected environment free from exposure that can worsen the *covered person's* physical or mental condition.

Master group contract means the document, including the *certificate*, together with any riders, amendments and endorsements, which describe the agreement between *us* and the *group plan sponsor*.

Maximum allowable fee for a *covered expense*, other than *emergency care* services provided by *non-network providers* in a *hospital's* emergency department, is the lesser of:

- The fee charged by the provider for the services;
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;
- The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
- The fee based upon rates negotiated by *us* or other payors with one or more *network providers* in a geographic area determined by *us* for the same or similar services;

GLOSSARY (continued)

- The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare & Medicaid Services (CMS) annually; or

- The fee based on a percentage determined by *us* of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

Maximum allowable fee for a *covered expense* for *emergency care* services provided by *non-network providers* in a *hospital's* emergency department is an amount equal to the greatest of:

- The fee negotiated with *network providers*;
- The fee calculated using the same method to determine payments for *non-network provider* services; or
- The fee paid by *Medicare* for the same services.

The bill *you* receive for services from *non-network providers* may be significantly higher than the *maximum allowable fee*. In addition to *deductibles*, *copayments* and *coinsurance*, if any, *you* are responsible for the difference between the *maximum allowable fee* and the amount the provider bills *you* for the services. Any amount *you* pay to the provider in excess of the *maximum allowable fee* will not apply to *your out-of-pocket limit* or *deductible*, if any.

Medicaid means a state program of medical care for needy persons, as established under Title 19 of the Social Security Act of 1965, as amended.

Medically necessary means health care services that a *health care practitioner* exercising prudent clinical judgment would provide to his or her patient for the purpose of preventing, evaluating, diagnosing or treating a *sickness* or *bodily injury*, or its symptoms. Such health care service must be:

- In accordance with nationally recognized standards of medical practice;

- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's *sickness* or *bodily injury*;

- Not primarily for the convenience of the patient, physician or other health care provider;

- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness* or *bodily injury*; and

- Performed in the least costly site.

GLOSSARY (continued)

For the purpose of *medically necessary*, generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Medicare means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

Mental health services mean those diagnoses and treatments related to the care of a *covered person* who exhibits a mental, nervous or emotional condition classified in the Diagnostic and Statistical Manual of Mental Disorders.

Morbid obesity means a body mass index (BMI) as determined by a *health care practitioner* as of the date of service of:

- Being at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables;
- 35 kilograms or greater per meter squared (kg/m^2) with an associated comorbidity or coexisting medical conditions such as hypertension, life-threatening cardiopulmonary conditions, sleep apnea, type II diabetes; or joint disease that is treatable, if not for the obesity; or
- 40 kilograms or greater per meter squared (kg/m^2) without such comorbidity.

H240300GA 01/19

N

Network health care practitioner means a *health care practitioner*, who has been designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* to provide services to all *covered persons. Network health care practitioner* designation by *us* may be limited to specified services.

Network hospital means a *hospital* which has been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* to provide services to all *covered persons. Network hospital* designation by *us* may be limited to specified services.

Network provider means a *hospital*, *health care treatment facility*, *health care practitioner*, or other health services provider who is designated as such or has signed an agreement with *us* as an independent contractor or who has been designated by *us* to provide services to all *covered persons. Network provider* designation by *us* may be limited to specified services.

Non-network health care practitioner means a *health care practitioner* who has not been designated by *us* as a *network health care practitioner.*

Non-network hospital means a *hospital* which has not been designated by *us* as a *network hospital*.

Non-network provider means a *hospital*, *health care treatment facility*, *health care practitioner*, or any other health services provider who has not been designated by *us* as a *network provider.*

GLOSSARY (continued)

Nurse means a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).
H241000 01/19

O

Observation status means *hospital outpatient* services provided to *you* to help the *health care practitioner* decide if *you* need to be admitted as an *inpatient*.

Open enrollment period means no less than a 31 day period of time, occurring annually for the *group*, during which *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under the *master group contract*.

Oral surgery means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include, but are not limited to, the following:

- Surgical removal of full bony impactions;
- Mandibular or maxillary implant;
- Maxillary or mandibular frenectomy;
- Alveolectomy and alveoplasty;
- Orthognathic *surgery*;
- *Surgery* for treatment of temporomandibular joint syndrome/dysfunction; and
- Periodontal surgical procedures, including gingivectomies.

Originating site means the location of a *covered person* at the time the *telehealth* or *telemedicine* service is being furnished.

Out-of-pocket limit means the amount of *covered expenses* which must be paid by *you*, either individually or combined as a covered family, per *year* before a benefit percentage will be increased.

Outpatient means *you* are not *confined* as a registered bed patient.

Outpatient surgery means *surgery* performed in a *health care practitioner's* office, *ambulatory surgical center*, or the *outpatient* department of a *hospital*.
H241600 01/19

P

Palliative care means care given to a *covered person* to relieve, ease, or alleviate, but not to cure, a *bodily injury* or *sickness*.

Partial hospitalization means services provided by a *hospital* or *health care treatment facility* in which patients do not reside for a full 24-hour period:

- For a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week;

GLOSSARY (continued)

- That provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and

- That has physicians and appropriately licensed behavioral health practitioners readily available for the emergent and urgent needs of the patients.

The *partial hospitalization* program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered *partial hospitalization* services.

Partial hospitalization does not include services that are for:

- *Custodial care*; or
- Day care.

Periodontics means the branch of dentistry concerned with the study, prevention, and treatment of diseases of the tissues and bones supporting the teeth. *Periodontics* includes the following dental procedures, related tests or treatment and follow-up care:

- Periodontal maintenance;
- Scaling and root planing;
- Gingivectomy;
- Gingivoplasty; or
- Osseous surgical procedures.

Pre-surgical/procedural testing means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;
- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and
- The tests must be for the same *bodily injury* or *sickness* causing *you* to be *hospital confined* or to have the *outpatient surgery* or procedure.

Preauthorization means approval by *us*, or *our* designee, of a service prior to it being provided. Certain services require medical review by *us* in order to determine eligibility for coverage.

Preauthorization is granted when such a review determines that a given service is a *covered expense* according to the terms and provisions of the *master group contract.*

GLOSSARY (continued)

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be written by a *health care practitioner* and provided to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury*, which is covered under this plan, or for drugs, medicines or medications on the Preventive Medication Coverage *drug list.* The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Preventive Medication Coverage *drug list.* The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner*. The *prescription* must include at least:

- *Your* name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *health care practitioner.*

Preventive services means services in the following recommendations appropriate for *you* during *your* plan *year*:

- Services with an A or B rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF).
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- Preventive care for women provided in the comprehensive guidelines supported by HRSA.

For the recommended *preventive services* that apply to *your* plan *year*, refer to the www.healthcare.gov website or call the customer service telephone number on *your* identification card.

Primary care physician means a *network health care practitioner* who provides initial and primary care services to *covered persons*, maintains the continuity of *covered persons* medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

A *primary care physician* is a *health care practitioner* in one of the following specialties:

- Family medicine/General practice;
- Internal medicine; and
- Pediatrics.

H242550 01/19

Q

Qualified provider means a person, facility or any other health care provider:

- That is licensed by the appropriate state agency to:
  - Diagnose or treat a *sickness* or *bodily injury*; or
  - Provide *preventive services*;
- That provides services within the scope of their license; and
- Whose primary purpose is to provide health care services.

H242560 01/19

GLOSSARY (continued)

R

Rehabilitation facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily to render physical and occupational therapies, diagnostic services and other therapeutic services.

Rescission, ***rescind*** or ***rescinded*** means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential treatment facility means an institution that:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although not licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;
- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;
- Provides programs such as social, psychological, family counseling and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and
- Provides structured activities throughout the day and evening, for a minimum of 6 hours a day.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

Retail clinic means a *health care treatment facility*, located in a retail store, that is often staffed by nurse practitioners and physician assistants who provide minor medical services on a "walk-in" basis (no appointment required).

Room and board means all charges made by a *hospital* or other *health care treatment facility* on its own behalf for room and meals and all general services and activities needed for the care of registered bed patients.

Routine nursery care means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. *Health care practitioner* visits are not considered *routine nursery care*. Treatment of a *bodily injury*, *sickness*, birth abnormality, or *congenital anomaly* following birth and care resulting from prematurity is not considered *routine nursery care*.
H242900 01/18

GLOSSARY (continued)

S

Self-administered injectable drugs means an FDA approved medication which a person may administer to himself or herself by means of intramuscular, intravenous, or subcutaneous injection, excluding insulin, and prescribed for use by *you.*

Service area means the geographic area designated by *us*, or as otherwise agreed upon between the *group plan sponsor* and *us* and approved by the Department of Insurance of the state in which the *master group contract* is issued, if such approval is required. The *service area* is the geographic area where the *network provider* services are available to *you.* A description of the *service area* is provided in the provider directories.

Sickness means a disturbance in function or structure of the body which causes physical signs or physical symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the body. The term also includes: (a) pregnancy; (b) any medical complications of pregnancy; and (c) *behavioral health*.

Skilled nursing facility means a licensed institution (other than a *hospital*, as defined) which meets all of the following requirements:

- It must provide permanent and full-time bed care facilities for resident patients;
- It must maintain, on the premises and under arrangements, all facilities necessary for medical care and treatment;
- It must provide such services under the supervision of physicians at all times;
- It must provide 24-hours-a-day nursing services by or under the supervision of a registered nurse; and
- It must maintain a daily record for each patient.

A *skilled nursing facility* is not, except by incident, a rest home, a home for the care of the aged, or engaged in the care and treatment of *chemical dependency*.

Small employer means an *employer* who employed an average of one but not more than 50 *employees* on business days during the preceding calendar year and who employs at least one *employee* on the first day of the *year*. All subsidiaries or affiliates of the *group plan sponsor* are considered one *employer* when the conditions specified in the "Subsidiaries or Affiliates" section of the *master group contract* are met.

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth (for example a tooth that has not been previously broken, chipped, filled, cracked or fractured).

GLOSSARY (continued)

Special enrollment date means the date of:

- Change in family status after the *eligibility date*;
- Loss of other coverage under another group health plan or other *health insurance coverage*;
- COBRA exhaustion;
- Loss of coverage under *your employer's* alternate plan;
- Termination of your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility; or
- Eligibility for a premium assistance subsidy under *Medicaid* or CHIP.

To be eligible for special enrollment, *you* must meet the requirements specified in the "Special enrollment" provision within the "Eligibility and Effective Dates" section of this *certificate.*

Specialty care physician means a *health care practitioner* who has received training in a specific medical field other than the specialties listed as primary care.

Specialty drug means a drug, medicine, medication, or biological used as a specialized therapy developed for chronic, complex *sicknesses* or *bodily injuries*. *Specialty drugs* may:

- Be injected, infused or require close monitoring by a *health care practitioner* or clinically trained individual;
- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

Surgery means procedures categorized as Surgery in either the:

- Current Procedural Terminology (CPT) manuals published by the American Medical Association; or
- Healthcare Common Procedure Coding (HCPCS) Level II manual published by the Centers for Medicare & Medicaid Services (CMS).

The term *surgery* includes, but is not limited to:

- Excision or incision of the skin or mucosal tissues;
- Insertion for exploratory purposes into a natural body opening;
- Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes;
- Treatment of fractures;
- Procedures to repair, remove or replace any body part or foreign object in or on the body; and
- Endoscopic procedures.

Surgical assistant means a *health care practitioner* who assists at *surgery* and is not a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO) or Doctor of Podiatric Medicine (DPM), or where state law does not require that specific *health care practitioners* be treated and reimbursed the same as an MD, DO or DPM.
H243800 01/19

GLOSSARY (continued)

T

Telehealth means an audio and video real-time interactive communication between a patient and *a health care practitioner* at a *distant site*.

Telemedicine means services other than *telehealth,* provided via telephonic or electronic communications.

Total disability or ***totally disabled*** means *your* continuing inability, as a result of a *bodily injury* or *sickness,* to perform the material and substantial duties of any job for which *you* are or become qualified by reason of education, training or experience.

The term also means a *dependent's* inability to engage in the normal activities of a person of like age. If the *dependent* is employed, the *dependent* must be unable to perform his or her job.
H244050 01/19

U

Urgent care means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires attention without delay but that does not pose a threat to life, limb or permanent health of the *covered person*.

Urgent care center means any licensed public or private non-*hospital free-standing facility* which has permanent facilities equipped to provide *urgent care* services on an *outpatient* basis.
H244200 01/19

V

W

Waiting period means the period of time, elected by the *group plan sponsor*, that must pass before an *employee* is eligible for coverage under the *master group contract.*

We, us or ***our*** means the offering company as shown on the cover page of the *master group contract* and *certificate*.
H244400 01/19

X

GLOSSARY (continued)

Y

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *master group contract,* the first *year* begins for *you* on the *effective date* of *your* coverage and ends on the following December 31st.

You or ***your*** means any *covered person.*

Z

H244600 07/07

GLOSSARY – PHARMACY SERVICES

All terms used in the "Schedule of Benefits – Pharmacy Services," "Covered Expenses – Pharmacy Services" and "Limitations and Exclusions – Pharmacy Services" sections have the same meaning given to them in the "Glossary" section of this *certificate,* unless otherwise specifically defined below:

A

B

Brand-name drug means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand-name by an industry-recognized source used by *us.*

C

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Copayment means the specified dollar amount to be paid by *you* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Cost share means any applicable *prescription drug deductible, copayment* and *coinsurance* that *you* must pay per *prescription* fill or refill.

D

Default rate means the fee based on rates negotiated by *us* or other payers with one or more *network providers* in a geographic area determined by *us* for the same or similar *prescription* fill or refill.

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is commonly prescribed to treat a particular condition, as determined by *us*.

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by *us.* The *drug list* identifies categories of drugs, medicines or medications and supplies by applicable levels, if any, and indicates applicable *dispensing limits, specialty drug* designation and/or any *prior authorization* or *step therapy* requirements. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* ID card to obtain the *drug list.* The *drug list* is subject to change without notice.

GLOSSARY – PHARMACY SERVICES (continued)

E

F

G

Generic drug means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by the chemical name, or any drug product that has been designated as generic by an industry-recognized source used by *us*.

H

I

J

K

L

Legend drug means any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits dispensing without prescription."

Level 1 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 1.

Level 2 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 2.

Level 3 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 3.

Level 4 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 4.

GLOSSARY – PHARMACY SERVICES (continued)

M

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by *us*, and delivers covered *prescription* drug, medicine or medication fills or refills through the mail to *covered persons.*

N

Network pharmacy means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

O

P

Pharmacist means a person, who is licensed to prepare, compound and dispense medication, and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where *prescription* drugs, medicines or medications are dispensed by a *pharmacist.*

Prescription drug deductible means the specified dollar amount for *prescription* drug *covered expenses* which *you,* either individually or combined as a covered family, must pay per *year* before *we* pay *prescription* drug benefits under the *master group contract.* These expenses do not apply toward any other *deductible,* if any, stated in the *master group contract.*

GLOSSARY – PHARMACY SERVICES (continued)

Prior authorization means the required prior approval from *us* for the coverage of certain *prescription* drugs, medicines or medications, including *specialty drugs*. The required prior approval from *us* for coverage includes the dosage, quantity and duration, as *medically necessary* for the *covered person.*

Q

R

S

Specialty pharmacy means a *pharmacy* that provides covered *specialty pharmacy* services, as defined by *us*, to *covered persons.*

Step therapy means a type of *prior authorization*. *We* may require *you* to follow certain steps prior to *our* coverage of some medications, including *specialty drugs*. *We* may also require *you* to try similar drugs, medicines or medications, including *specialty drugs* that have been determined to be safe, effective and more cost-effective for most people with *your* condition. Alternatives may include over-the-counter drugs, *generic drugs* and *brand-name drugs*.

T

U

V

W

X

Y

Z

H244700 01/19

GRIEVANCE PROCEDURES AMENDMENT

This amendment is made part of the *master group contract* to which it is attached.

All terms used in this amendment have the same meaning given to them in the *certificate* unless otherwise specifically defined in this amendment. Except as modified below all terms, conditions and limitations of the *master group contract* apply.

The "Grievance Procedures" section is replaced with the following:

Definitions

Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make a payment:

- In whole or in part for a benefit;
- A determination of *your* eligibility for group coverage under the *master group contract*;
- Any *rescission* of coverage or cancellation of coverage not attributed to a failure to pay premiums that is applied retroactively.

Appeal means a written, oral or *electronic* request for reconsideration of an *adverse benefit determination.*

Authorized representative means someone *you* have appropriately authorized to act on *your* behalf, including *your* health care provider.

Complaint means a written communication submitted by *you* or *your authorized representative* regarding dissatisfaction with any aspect of the plan, other than a claim or service denial, including a previous problem that is not resolved to *your* satisfaction.

Experimental treatment determination means a determination by *us* or on *our* behalf, which denies in part or in full, requested services to which all of the following apply:

- The proposed treatment has been reviewed;
- Based on the information provided, a determination has been made by *us* or on *our* behalf that the services were considered *experimental, investigational,* or *for research purposes*; and
- Based on the information provided, *we* have denied either the proposed treatment or payment for the treatment.

Independent Review Organization (IRO) means an organization of medical professionals with no connection to *your* health plan, qualified to review *your* dispute.

Review panel means two or more of *our* representatives who:

- Did not participate in the initial *adverse benefit determination* or any prior *appeal* decision; and
- Are not subordinates of the individual who made the initial *adverse benefit determination* or prior *appeal* decision.

If the *appeal* involves a medical necessity or experimental/investigational *adverse benefit determination,* at least one panel reviewer must:

GRIEVANCE PROCEDURES AMENDMENT (continued)

- Hold an active, unrestricted medical license;
- Be from the same or similar specialty who typically treats the medical condition or provides the treatment in question; and
- Be a *health care practitioner* other than *our* medical director.

Urgent care claim means a claim for treatment or services, that if delayed could seriously jeopardize the life or health of the *covered person*, their ability to regain maximum function or in the opinion of the treating physician would subject the *covered person* to severe pain that cannot be adequately managed without the treatment.

Complaints

If *you* have a *complaint* regarding dissatisfaction with any aspect of the plan, please call *our* Customer Service Department as soon as possible. The toll-free number is on *your* identification card or *you* may write to *us* at the address listed below. *We* will review the *complaint* and *you* will be notified of a final decision not later than 60 days after *our* receipt of the *complaint.* At any time, *you* may file an *appeal* described below.

Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

Internal appeals

First level review

If *you* are dissatisfied with *our* determination of *your* claim, *you* may *appeal* the decision. *Appeals* must be submitted to *us* within 180 calendar days from the receipt of an *adverse benefit determination.* *Appeals* involving medical necessity or experimental/investigational *adverse benefit determinations* can be submitted by *you*, *your* provider or *your authorized representative.* All other *appeals* can be submitted by *you* or *your authorized representative.* A request for a first level review of an *adverse benefit determination* may be made by *you* or *your authorized representative* orally, by *electronic* means or in writing at the following address:

Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

We will acknowledge receipt in writing within five business days of receipt. *We* will investigate the *appeal* and notify *you* or *your authorized representative* of the determination no later than:

- 15 calendar days after the date *we* received the request for a pre-service or concurrent *adverse benefit determination*; or
- 30 calendar days after the date *we* received the request for post-service *adverse benefit determinations.*

GRIEVANCE PROCEDURES AMENDMENT (continued)

Expedited internal review

You or *your authorized representative* may request an expedited internal review of an adverse *urgent-care claim* decision orally, *electronically* or in writing. *We* will notify *you* or *your authorized representative* of *our* decision as expeditiously as the *covered person's* condition requires, but in no event more than 48 hours of receipt of the request. Written resolution will be sent to *you* or *your authorized representative* within three calendar days.

Second level panel review

If *you* are dissatisfied or unable to resolve *your* concerns through the first level review, *you* or *your authorized representative* may request a second level panel review orally, in writing or *electronically* at the address provided on the denial letter *you* received.

A *review panel* will investigate *your appeal.* *We* will notify *you* or *your authorized representative* of the *review panel's* determination no later than:

- 15 calendar days after the date *we* received the request for a pre-service or concurrent *adverse benefit determination*; or
- 30 calendar days after the date *we* received the request for post-service *adverse benefit determinations.*

Expedited second level panel review

You or *your authorized representative* may request an expedited internal review of an adverse *urgent-care claim* decision orally or in writing. A *review panel* will investigate *your appeal.* *We* will notify *you* or *your authorized representative* of the decision as expeditiously as the *covered person's* condition requires, but in no event more than 24 hours from the receipt of the request.

Exhaustion of remedies

You must complete all levels of the *appeal* process available to *you* under state or federal law before filing a lawsuit. This assures that both *you* and *we* have a full and fair opportunity to complete the record and resolve the dispute. Contact *us* if *you* believe *your* condition requires the use of the shorter time lines applicable to emergency health conditions.

The *appeal* process, however, does not stop *you* from pursuing other appropriate remedies, including injunctive relief or equitable relief, if the requirement of exhausting the process for *appeals*, including the emergency *appeal* process, would place *your* health in serious jeopardy.

A coverage denial does not mean that *your* provider cannot provide the service or supply. *Our* denial only means *we* will not pay for the service or supply, unless *our* decision is reversed on *appeal* or in a subsequent lawsuit.

GRIEVANCE PROCEDURES AMENDMENT (continued)

External review

If *you* or *your authorized representative* disagree with the outcome of the first and second level review decision, *you* or *your authorized representative* have the right to request an external review by an *Independent Review Organization* (*IRO)* if the *adverse benefit determination* involves an *experimental treatment determination, medically necessary* determination, a denial based on medical judgment, or a *rescission* of coverage. *Adverse benefit determinations* related to eligibility to participate in the plan are not eligible for external review.

You or *your authorized representative* must exhaust the internal *appeal* process before requesting an external review by an *IRO*. If *you* or *your authorized representative* wishes to file a request for an external review the request must be submitted in writing to the address listed below and received within four months or the next business day following the four month period from the receipt of the *adverse determination.*

Grievance and Appeal Department
P.O. Box 11268
Green Bay, WI 54307-1268

Within five business days of *our* receipt of the request, an *IRO* will be assigned to *your* case through an unbiased rotating selection process. The assigned *IRO* will send *you* or *your authorized representative* a notice of acceptance which will include notice of the right to submit additional information within ten business days of receipt of the notice from the *IRO*. The assigned *IRO* will also deliver a notice of the final external review decision in writing to *you, your authorized representative*, and *us* within 45 days of their receipt of the request.

Should the *IRO* find in *your* or *your authorized representative's* favor in whole or in part, *we* will take the necessary actions to ensure the implementation of the *IRO* decision.

Expedited external review

An external expedited review is a review involving cases where the normal duration of the external independent review process would jeopardize a *covered person's* life, health or ability to regain maximum function. This request should be submitted to *us* immediately.

The *IRO* must provide a decision to *you* or *your authorized representative* and to *us* within 72 hours of the *IRO's* receipt of the request.

Once the *IRO* makes a final coverage decision, the final coverage decision is binding on *us* and *we* will take the necessary actions to ensure the implementation of the *IRO* decision.

Legal actions and limitations

No legal action to recover on the *master group contract* may be brought until 60 days after written proof of loss has been given in accordance with the "Proof of loss" provision of the *master group contract.*

GRIEVANCE PROCEDURES AMENDMENT (continued)

No legal action to recover on the *master group contract* may be brought after three years from the date written proof of loss is required to be given.

Humana Employers Health Plan of Georgia, Inc.

Bruce Broussard
President

CONSUMER CHOICE OPTION RIDER

A Consumer Choice Option Provider is a *non-network health care practitioner*, who has been nominated by an *employee* to function as a *network health care practitioner* for use by a *covered person.* Such health services provider must meet the following requirements:

- Be located within and licensed by the State of Georgia;
- Agree to accept reimbursement from both the plan and the *employee* at the rates and on the terms and conditions applicable to similarly situated *network health care practitioners* and further agrees that the *employee* cannot be balance billed;
- Agree to adhere to the managed care plan's quality assurance requirements and to provide the plan with necessary medical information related to such care;
- Meet all other reasonable criteria as required by the managed care plan of *network health care practitioners*; and
- Be free of federal and state sanctions.

All services are subject to all the terms and provisions, limitations and exclusions of the *master group contract*. *Covered expenses* received from a Consumer Choice Option Provider will be covered at the *network health care practitioner* benefits level, as indicated on *your* schedule of benefits or any applicable rider or amendment.
H3031000

Humana Employers Health Plan of Georgia, Inc.

Bruce Broussard
President

H3031010GA 09/06

Humana.

Administrative Office:
900 Ashwood Parkway, Suite 400
Atlanta, GA 30338

1100 Employers Boulevard
Green Bay, Wisconsin 54344

OFFERED BY
HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.

NOTICE

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

FEDERAL NOTICES

The following pages contain important information about certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

This section includes notices about:

Federal legislation

- **Women's health and cancer rights act**
- **Statement of rights under the newborns' and mothers' health Protection act**
- **Medical child support orders**
- **General notice of COBRA continuation of coverage rights**
- **Tax equity and fiscal responsibility act of 1982 (TEFRA)**
- **Family and medical leave act (FMLA)**
- **Uniformed services employment and reemployment rights act of 1994 (USERRA)**
- **Your rights under ERISA**
- **Patient protection act**

FEDERAL NOTICES (continued)

Federal legislation

Women's health and cancer rights act of 1998
Required coverage for reconstructive surgery following mastectomies

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

Statement of rights under the newborns' and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

FEDERAL NOTICES (continued)

Medical child support orders

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

General notice of COBRA continuation coverage rights

Introduction

You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

FEDERAL NOTICES (continued)

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

FEDERAL NOTICES (continued)

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage*** - If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage;

- ***Second qualifying event extension of 18-month period of continuation coverage*** - If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

FEDERAL NOTICES (continued)

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

FEDERAL NOTICES (continued)

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options:

- ***Option 1*** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- ***Option 2*** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- ***Category 1*** Medicare eligibles are:
  - Covered employees in active service who are age 65 or older who choose Option 1;
  - Age 65 or older covered spouses; and
  - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;
- ***Category 2*** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:
  - Retired employees and their spouses; or
  - Covered dependents of a covered employee, other than his or her spouse.

Calculation and payment of benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

FEDERAL NOTICES (continued)

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

FEDERAL NOTICES (continued)

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other information

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the plan and benefits

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office;
- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator;
- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

FEDERAL NOTICES (continued)

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue group health plan coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Claims determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;

FEDERAL NOTICES (continued)

- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;

- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;

- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;

- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

FEDERAL NOTICES (continued)

Patient Protection Act

Humana generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

If your plan provides coverage for obstetric or gynecological care, you do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to this care from a health care professional in our network who specialize in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

Appeal and External Review Notice

The following pages contain important information about Humana's claims procedures, internal appeals and external review. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. The Patient Protection and Affordable Care Act (PPACA) including all regulation enforcing PPACA established additional requirements for claims procedures, internal appeal and *external review* processes. Humana complies with these standards. In addition to the procedures below, you should also refer to your insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage).

Definitions

Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit based on:

- A determination of your eligibility to participate in the plan or health insurance coverage;
- A determination that the benefit is not covered;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

An *adverse benefit determination* also includes any rescission of coverage.

Claimant means a covered person (or authorized representative) who files a claim.

Clinical peer reviewer is:

- An expert in the treatment of your medical condition that is the subject of an *external review*;
- Knowledgeable about the recommended healthcare service or treatment through recent or current actual clinical experience treating patients with the same or similar to your medical condition;
- Holds a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the *external review*;
- Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the *clinical peer reviewer's* physical, mental or professional competence or moral character; and

Appeal and External Review Notice (continued)

- Does not have a material professional, family or financial conflict of interest with the *claimant*, Humana and any of the following:

  - The healthcare provider, the healthcare provider's medical group or independent practice association recommending the healthcare service or treatment;
  - The facility at which the recommended healthcare service or treatment would be provided; or
  - The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended.

Commissioner means the Insurance and Fire Safety Commissioner.

Concurrent-care decision means a decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Evidence-based standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

External review means a review of an *adverse benefit determination* including a *final adverse benefit determination* conducted by an *Independent review organization (IRO).*

Final adverse benefit determination means an *adverse benefit determination* that has been upheld by us at the completion of the internal appeals process or when the internal appeals process has been exhausted.

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer means the offering company listed on the face page of your Certificate of Insurance and referred to in this document as "Humana," "we," "us," or "our."

Independent review organization (IRO) means an entity that conducts independent *external reviews* of *adverse benefit determinations* and *final adverse benefit determinations.* All *IRO's* must be accredited by a nationally recognized private accrediting organization and have no conflicts of interest to influence its independence.

Medical or scientific evidence means evidence found in the following sources:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

Appeal and External Review Notice (continued)

- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

- Medical journals recognized by the Secretary of Health and Human Services;

- The following standard reference compendia:

  - The American Hospital Formulary Service–Drug Information;
  - Drug Facts and Comparisons;
  - The American Dental Association Accepted Dental Therapeutics; and
  - The United States Pharmacopoeia–Drug Information;

- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

  - The federal Agency for Healthcare Research and Quality;
  - The National Institutes of Health;
  - The National Cancer Institute;
  - The National Academy of Sciences;
  - The Centers for Medicare & Medicaid Services;
  - The federal Food and Drug Administration; and
  - Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

- Any other *medical or scientific evidence* that is comparable to the sources listed above.

Preliminary review means a review by Humana of an *external review* request to determination if:

- You are or were covered under the plan at the time a service was recommended, requested, or provided;

- The service is covered under the plan except when we determine the service is:

  - Not covered because it does not meet plan requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness; or
  - Experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the plan.

- In the case of experimental or investigational treatment:

  - Your treating physician has certified <u>one</u> of the following situations is applicable:

    - Standard services have not been effective in improving your condition;
    - Standard services are not medically appropriate for you; or
    - There is no available standard service covered by the plan that is more beneficial to you than the recommended or requested service.

- The treating physician certifies in writing:
  - The recommended service is likely to be more beneficial to you, in the physician's opinion, than any available standard services; or
  - Scientifically valid studies using accepted protocols demonstrate the service is likely to be more beneficial to you than any available standard services and the physician is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition.

- The internal appeals process has been exhausted as specified under the "Exhaustion of remedies" section;
- You have provided all information required to process an *external review*; including:
  - An *external review* request form provided with the *adverse benefit determination* or *final adverse benefit determination*; and
  - Release forms authorizing us to disclose protected health information that is pertinent to the *external review*.

Post-service claim means any claim for a benefit under a *group health plan* that is not a *pre-service claim*.

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care claim means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an *urgent-care claim*. However, any claim a physician, with knowledge of a covered person's medical condition, determines is an "*urgent-care claim*" will be treated as a "claim involving urgent care."

Claim procedures

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

Appeal and External Review Notice (continued)

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five days (or as soon as possible but not more than 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirements, it will be returned to the submitter.

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim, an internal appeal or an *external review*. The designation must be in writing and must be made by the covered person on Humana's Appointment of Representation (AOR) Form or on a form approved in advance by Humana. An assignment of benefits does not constitute designation of an authorized representative.

Appeal and External Review Notice (continued)

Humana's AOR Form must be submitted to Humana at the time or prior to the date an authorized representative commences a course of action on behalf of the covered person. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the covered person to the covered person, which Humana may verify with the covered person prior to recognizing authorized representative status.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an *urgent-care claim* will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- ***Pre-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

  This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the *claimant* of the circumstances requiring the extension and the date by which Humana expects to make a decision.

  If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- ***Urgent-care claims*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

  Notice of a favorable or *adverse benefit determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 24 hours after receiving the *urgent-care claim*.

  If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim.* The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

Appeal and External Review Notice (continued)

Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or
- The end of the period afforded the *claimant* to provide the specified additional information.

- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

  Humana will decide *urgent-care claims* involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- ***Post-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

  This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected *claimant* of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

  If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the *claimant* responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claims*, notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than three days after oral notification.

A claims denial notice will convey the specific reason for the *adverse benefit determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim and a copy of the rule, protocol or similar criterion will be provided to *claimants*, free of charge. In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the *claimant's* right to bring a civil action under ERISA Section 502(a) following an *adverse benefit determination* on review.

Appeal and External Review Notice (continued)

If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

Contact information

For questions about your rights, this notice, or assistance, you can contact: Humana, Inc. at www.humana.com or the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

You may contact the *commissioner* for assistance at any time at the address and telephone number below:

Georgia Office of Insurance and Safety Fire Commissioner
Two Martin Luther King Jr. Drive
West Tower, Suite 704
Atlanta, GA 30334

Phone: 404-656-2056 or
800-656-2298 (toll free) or 404-656-2070

Website: www.oci.ga.gov

Consumer Services Division
Two Martin Luther King Jr. Drive
West Tower, Suite 716
Atlanta, GA 30334
Phone: 404-656-2070 or 800-656-2298 (toll free)
Website: http://www.oci.ga.gov/consumerservice/home.aspx

Appeal and External Review Notice (continued)

Internal appeals and external review of adverse benefit determinations

Internal appeals

A *claimant* must appeal an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a *claimant* by means of written application to Humana, in person, or by mail, postage prepaid.

A *claimant*, on appeal, may request an expedited internal appeal of an adverse *urgent-care claim* decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the *claimant* by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

A *claimant* may request an expedited *external review* at the same time a request is made for an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when you are receiving an ongoing course of treatment.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

On appeal, a *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse benefit determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

If new or additional evidence is relied upon or if new or additional rational is used during the internal appeal process, Humana will provide the *claimant*, free of charge, the evidence or rational as soon as possible and in advance of the appeals decision in order to provide the *claimant* a reasonable opportunity to respond.

Appeal and External Review Notice (continued)

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

- ***Urgent-care claims*** - As soon as possible but not later than 72 hours after Humana receives the appeal request;
- ***Pre-service claims*** - Within a reasonable period but not later than 30 days after Humana received the appeal request;
- ***Post-service claims*** - Within a reasonable period but not later than 60 days after Humana receives the appeal request;
- ***Concurrent-care decisions*** - Within the time periods specified above depending on the type of claim involved.

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse benefit determination*;
- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the *claimant*, free of charge;
- A statement of the *claimant's* right to *external review*, a description of the *external review* process, and the forms for submitting an *external review* request, including release forms authorizing Humana to disclose protected health information pertinent to the *external review*;
- A statement about the *claimant's* right to bring an action under §502(a) of ERISA;
- If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

Appeal and External Review Notice (continued)

Exhaustion of remedies

Upon completion of the internal appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the plan. If Humana fails to adhere to all requirements of the internal appeal process, except for failures that are based on a minimal error, the claim shall be deemed to have been denied and the *claimant* may request an *external review.*

After exhaustion of remedies, a *claimant* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

External review

Within four months after a *claimant* receives notice of an *adverse benefit determination* or *final adverse benefit determination* the *claimant* may request an *external review* if the determination concerns treatment that is *experimental, investigational* or not *medically necessary* or the determination concerns a rescission of coverage. The request for *external review* must be made in writing to the *commissioner.* Please refer to the section titled "Expedited external review" if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

Within one business day after the receipt of a request for *external review,* the *commissioner* will send a copy of the request to Humana. Within five business days, we will complete a *preliminary review* of the request.

Within one business day after we complete the *preliminary review,* we will notify the *claimant* and the *commissioner* in writing whether:

- The request is complete and is eligible for *external review*;
- The request is not complete and the information or materials needed to make the request complete; or
- The request is not eligible for *external review,* the reasons for ineligibility and the *claimant's* right to appeal to the *commissioner.* If appealed, the *commissioner* may determine that the request is eligible for *external review.*

Within one business day after the *commissioner* receives notice that the request is eligible for *external review,* the *commissioner* will:

- Impartially assign an *IRO* from a list compiled and maintained by the *commissioner* to conduct the *external review*;
- Provide Humana with the name of the *IRO*. Within five business days after the date of receipt of this notice, we will provide the *IRO* with all documents and information we considered in making the *adverse benefit determination* or *final adverse benefit determination*;

Appeal and External Review Notice (continued)

- Notify the *claimant* in writing of the following:

  - The eligibility of the request and acceptance for *external review*; and
  - The right to submit additional information in writing to the *IRO* and the time limits to submit the information.

Any information received by the *IRO* will be forwarded to Humana within one business day of receipt. Upon receipt of additional information, we may reconsider the *adverse benefit determination* or *final adverse benefit determination.* If we reverse the *adverse benefit determination* or *final adverse benefit determination*, the *external review* will be terminated and we will provide coverage for the service. We will immediately notify the *claimant*, the *IRO*, and the *commissioner* in writing of our decision.

The *IRO* will review all of the information received including, if available and considered appropriate the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant*, and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include applicable *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

If the *external review* involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review*, the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review.* The *clinical peer reviewer* will review all of the information and within 20 days after being selected, will provide a written opinion to the *IRO* on whether the service should be covered. The written opinion will include:

- A description of the medical condition;
- A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the service is more likely than not to be beneficial to you than any available standard services;
- The adverse risks of the service would not be substantially increased over those of available standard services;
- A description and analysis of any *medical or scientific evidence*, or *evidence-based standard* considered in reaching the opinion;

Appeal and External Review Notice (continued)

- Information on whether the reviewer's rationale for the opinion is based on either:

  - The service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

  - *Medical or scientific evidence* or *evidence-based standards* demonstrate that the expected benefits of the service is more likely than not to be beneficial to you than any available standard health care service and the adverse risks of the service would not be substantially increased over those of available standard services.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided in writing to the *claimant,* the *commissioner* and Humana within:

- 20 days after receipt of each *clinical peer reviewer* opinion for an experimental or investigational treatment; or
- 45 days after receipt of the request for an *external review.*

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination.* If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination.* If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO's* written notice of the decision will include:

- A general description of the reason for the request for *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the *external review*;
- The date the *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards,* considered in reaching the decision; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer*.

Immediately upon our receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse determination,* we will approve the service.

Expedited external review

You may request an expedited *external review* from the *commissioner*:

- At the same time you request an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when you are receiving an ongoing course of treatment; or

Appeal and External Review Notice (continued)

- When you receive an *adverse benefit determination* or *final adverse benefit determination* of:
  - An *urgent-care claim*;
  - An admission, availability of care, continued stay or health care service for which you received emergency services, but you have not been discharged from the facility; or
  - An experimental or investigational treatment if the treating physician certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

The *commissioner* will immediately send a copy of the request to Humana and upon receipt; we will immediately complete a *preliminary review* of the request. We will immediately notify the *claimant* and the *commissioner* of the *preliminary review* determination. If we determine the request is not eligible, the notice will advise you of your right to appeal to the *commissioner*. If appealed, the *commissioner* may determine that the request is eligible for *external review*.

Immediately after the commissioner receives notice that the request is eligible for *external review*, the *commissioner* will:

- Impartially assign an *IRO* to conduct the expedited *external review*.
- Provide Humana with the name of the *IRO* and we will immediately provide the *IRO* with all necessary documents and information.

The *IRO* will review all of the information received including, if available and considered appropriate, the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant* and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

If the expedited *external review* request involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review*, the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review*. The *clinical peer reviewer* will:

- Review all of the information noted above including whether:
  - The recommended service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

- Medical or scientific evidence or *evidence-based standards* demonstrate that the expected benefits of the recommended service is more likely than not to be beneficial to you than any available standard service and the adverse risks of the recommended service would not be substantially increased over those of available standard services.

- Provide an opinion to the *IRO* as expeditiously as your condition or circumstances require, but in no event more than five calendar days after being selected.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided orally or in writing to the *claimant*, the *commissioner* and Humana within:

- 48 hours after receipt of each *clinical peer reviewer* opinion of an expedited *external review* for an experimental or investigational treatment; or
- 72 hours after the date of receipt of the request for an expedited *external review*.

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination.* If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination.* If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO* will send written confirmation within 48 hours of an oral decision and will include:

- A general description of the reason for the request for an expedited *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the expedited *external review*;
- The date the expedited *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards,* considered in reaching the decision, except in the case of experimental or investigational treatment; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer*.

Immediately upon receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse benefit determination,* we will approve the service.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.